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THE UNIVERSITY OF ALBERTA

AN ANALYSIS OF SOME OF THE INFLUENCES ON THE COLLECTIVE BARGAINING OF PHYSICAL AND OCCUPATIONAL THERAPISTS IN ALBERTA 1970 - 1985

by

Ian R. Brown

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION

FACULTY OF BUSINESS

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EDMONTON, ALBERTA
FALL, 1986

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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read and recommend to the faculty of Graduate Studies and Research, for acceptance, a thesis entitled "AN ANALYSIS OF SOME OF THE INFLUENCES ON THE COLLECTIVE BARGAINING OF PHYSICAL AND OCCUPATIONAL THERAPISTS IN ALBERTA 1970 - 1985", submitted by Ian R. Brown in partial fulfilment of the requirements for the degree of Master of Business Administration.

Edward G. Fisher
Supervisor

Date: 15 Oct/86

DEDICATION

In the course of life one encounters many types of people. Some exist to give and others to take. But occasionally one encounters a special type of person who strives to create an environment which gives others the chance to succeed. One such man is Dr. J. R. Thompson and it gives me great pleasure to dedicate this thesis to him.

ABSTRACT

The bargaining status of Physical and Occupational Therapists in Alberta has evolved from a consultative association, through a fledgling trade union and on to a fully fledged union, all within the space of ten years. This thesis looks as the influence of these changes in the bargaining status of physical and occupational therapists on their bargaining results during the 1970-1985 period, and attempts to draw some conclusions on what factors most significantly affect bargaining outcomes.

The thesis develops and tests an analytical model for the prediction of bargaining results, concluding that bargaining structure and the pattern-setting influence of Alberta nurses are more significant factors in the determination of bargaining results than is bargaining status.

ACKNOWLEDGEMENTS

Even though my name alone appears on this thesis, it represents the efforts of many more than one person. Jed Fisher has contributed more than anyone one else with his continued guidance through some very difficult times for both of us. I may not always have agreed with his points but I have always respected his views and appreciated his input, particularly when he took over the responsibility for the project from Brian Williams.

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Chris' views led me to revise large portions of my work that were ultimately discarded when he decided that it was best to retreat as the pressure on the project mounted. I thank Chris for his role in adding to the strength of my resolve to succeed.

To John Brown I express many thanks for his review of my earlier drafts and to Margaret Rodziewicz, I offer my sincerest thanks for her assistance is putting the thesis together. Without Margaret's help there is no question that this project would have remained an unrealized dream.

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INTRODUCTION

A. Unionization and Paramedical Professionals

Practitioners and students of collective bargaining often wonder about the impact of unionization on the settlement of terms and conditions of employment. In particular, professional groups such as therapists and nurses "...long excluded from coverage by virtually all labour codes in Canada..." (Thompson: 1982, p.385.) were seeing the apparent benefits of unionization in the gains of other groups around them. Like other workers in the private and public sectors, paramedical professionals in Alberta experienced considerable dissatisfaction with the terms and conditions of their employment during the 1970's. They perceived the gap between their wages and those of technicians to be closing as other groups appeared to reap the benefits of unionization. Yet they were reluctant to unionize themselves. The professional associations responded in part by engaging in consultative negotiations with their employers and some gains were made. The problem of rationalizing the role of the associations as both a professional body and a form of bargaining agent arose and caused considerable difficulty for many of the associations.

In 1973,

> The Supreme Court of Canada decision ... in Re: Service Employees International Union, Local No. 333 v. Nipawin District Staff Nurses' Association et al. (1973) 41 D.L.R. (3rd) 6 (Can.Sup.Ct.), crystallized the contradictions some associations have experienced in combining traditional professional activities and bargaining. (Thompson: 1982, p.388.)

The issue here was that professional associations, formed primarily to oversee the professionalism of an occupation, were acting as the vehicle for labour negotiations. It was the attitude of many, including the court as noted in the above decision, that professional associations should not engage in collective bargaining. The decision established that professional associations could not bargain, thereby creating the need for a separate body for collective bargaining. In 1976, Alberta nurses attempted to resolve these contradictions by forming the United Nurses of Alberta (previously the Staff Nurse Division of the Alberta Association of Registered Nurses [A.A.R.N.]) which made the other professional groups within the Alberta hospital industry take notice. Physical and occupational therapists in Alberta were facing similar problems.

B. Three Stages in the Evolution of Therapists' Bargaining

Physical and occupational therapists, who are the focus of this investigation, underwent three distinct changes in their bargaining status during the seventies. On December 10, 1970, the Association of Chartered Physio - Therapists of Alberta and the Alberta Society of Occupational Therapists, hereinafter referred to as the 'therapists', signed with their employer, the Alberta Hospital Association, a 'Recognition Agreement' (PERIOD ONE). This agreement established the therapists as a consultative association with limited bargaining power and specifically stated that

> ...as the (therapists) are only advisory to their respective members ...nothing in this agreement shall be construed as imposing upon these members acceptance of the conclusions reached by the

> (therapists) or as restricting the rights of such members to reject any or all terms and conditions which may be recommended to them....

The agreement, therefore, was a bundle of individual contracts of employment at common law.

The therapists worked under this arrangement until 1975 when a much stronger recognition clause was added to this agreement, stating

> ...the (employer) recognizes the (therapists) as the sole bargaining agent for all employees covered by this agreement.

This clause gave the therapists' associations exclusive bargaining rights, thereby making them a voluntarily recognized fledgling trade union (PERIOD TWO). In that year the agreement almost doubled in length and in the number of clauses. The therapists received a 35% salary increase in 1975, compared with only a 9% increase in the previous year.

Under the conditions of voluntary recognition, neither the therapists' associations nor the Alberta Hospital Association (AHA) had the right to enforce a collective agreement, since neither had formal status as the representative of the employees or as employer under the Labour Act. The therapists were working under an 'accommodation', which was fine as long as there were no serious disputes. If major disputes arose, the only way to enforce the collective agreement was through civil litigation. Being outside the Labour Act, the therapists could not legally strike and had no access to conciliation or mediation (1). As the writer personally witnessed during the 1978 negotiations, the

membership was becoming increasingly dissatisfied with what they considered to be poor bargaining settlements.

The outward manifestation of the therapists' dissatisfaction in 1978, was their consideration of the following three strategic options in an attempt to improve the terms and conditions of their employment:

1) continue as a voluntarily recognized bargaining agent and continue to seek improvements in wages, hours and working conditions through consultation;
2) form their own fully fledged union; or
3) join a larger union.

The circumstances under which therapists have bargained varied considerably over time. From the first negotiations in 1971, there was a feeling among therapists that they did not have the bargaining power necessary to achieve the gains they sought. This feeling led to the formation of a stronger, more formal negotiating committee in 1975, out of what was previously a relatively loose- knit, informal group of therapists. Yet the feeling of inadequate bargaining power still remained, reaching its peak in 1978, when two distinct views on how best to improve bargaining power emerged. On the one hand, it was felt that therapists should join a larger group and acquire improved bargaining power through increased size. On the other hand, many therapists believed that they, being professionals, should seek certification under the Alberta Labour Act and acquire the legal right to strike while steering clear of any link with 'trade unions' (as had earlier been the case with the nurses). The debate among therapists was lively and widespread, with some therapists going to great lengths, including litigation, to attempt to keep the profession from

becoming unionized.

The therapists' bargaining status remained unchanged until the latter part of 1979, when they moved from being a voluntarily recognized fledgling trade union to a fully fledged, certified trade union by joining the Health Sciences Association of Alberta (HSAA), a certified bargaining agent, as members of a para -medical professional unit (PERIOD THREE) [See Appendix A for a listing of all members in this unit]. In 1980, the first year of bargaining as a member of a fully-fledged trade union, the therapists received a salary increase of 23% compared to 6.6% in 1979. Since 1980, the minority interests of therapists, likely important at the time of joining the HSAA, may have been considerably diluted, or perhaps dissolved, in the larger unit, since wage settlements for therapists have not been significantly different from those of other members of the HSAA.

The therapists' bargaining history gives rise to a number of questions. First, were the 1975 and 1980 settlements the result of a change in therapists' bargaining status, or were they caused by other factors? Second, to what extent were the 1975 and 1980 changes in status translated into greater bargaining power relative to the employer? Finally, were benefits and/or costs associated with the transition from an association to a fledgling or voluntarily recognized union, and then to a fully fledged, certified trade union which is part of a much larger bargaining unit?

Some of the changes in bargaining power, as well as the resultant costs and benefits of these changes in bargaining status, will either be difficult to quantify or may be manifested only once over time. As well, both the climate in which a group bargains and the situations that a particular group faces changes continuously, making precise analysis of cause and effect difficult. Analysis of bargaining circumstances and results can offer some insights towards answering the questions posed above, which might be summarized into the statement: 'What value the struggle?'

Given the considerable effort made to attain a bargaining status that would hopefully improve the terms and conditions of employment and the attendant costs, both in terms of money and on the presumed adverse effects on the professional status of therapists, the question of 'what value the struggle' becomes very interesting. Answering this question requires an analysis of the results of the therapists' efforts, namely, the terms and conditions of employment attained under the new bargaining status. One can only gain insight into the value of the struggle, if the role of the changing bargaining status can be isolated from the impact of other factors that influence the terms and conditions of employment.

C. Purpose of the Thesis

The purpose of this thesis is to attempt to isolate the impact of bargaining status on the terms and conditions of employment. If successful, we may offer some insights into the value of fully fledged

trade union status in achieving bargaining gains in Alberta's hospital industry. At a minimum we shall derive insights into the factors influencing or determining therapists' wages in the Alberta economy, 1970 - 1985.

D. Organization of the Thesis

We will be reviewing the collective bargaining from the therapists' own perspective rather than from that of the employer. Chapter One, following, will provide background to the thesis and states the conceptual framework for the project. Chapter Two addresses the labour relations structure in the Alberta hospital industry. Chapter Three discusses the factors which influence bargaining outcomes. Chapter Four describes the general environment as well as hospital industry bargaining in Alberta. Chapter Five details the methodology for the work. Chapter Six provides the analysis and Chapter Seven, the conclusions.

FOOTNOTES

(1) In 1977 the therapists requested the Alberta Department of Mediation and Conciliation Services to appoint a conciliator under the provisions of Section 104 of the Alberta Labour Act (1973). The department refused to appoint a conciliator stating that the bargaining agent had no status under the Act and agreed only to send a conciliation officer to help reach agreement with the Alberta Hospital Association (AHA) on an informal basis. Technically, a case might have been made regarding a right to conciliation but the outcome of such a case was sufficiently uncertain that the therapists declined that option.

Without access to conciliation the therapists could not go on legal strike because they could not satisfy the preconditions to a strike set out in the Alberta Labour Act (1973).

It was clear from the discussions with the therapists' bargaining team that they were not disposed to strike in the first place, which demonstrates that the therapists had neither a practical nor a legal strike threat.

CHAPTER ONE

BACKGROUND AND CONCEPTUAL FRAMEWORK

1.1 Introduction

From the previous discussion we have seen that therapists have evolved through three stages in their search for increased bargaining power. In the final step they became a fully fledged trade union. The main reason for taking these steps was to positively influence the terms and conditions of their employment. In this chapter we start with a review of the literature on the impact of unionization on wages, we then review the Bilateral Monopoly Theory to demonstrate the link between unionization and power to influence wages, and we conclude with the development of an analytical model to guide our subsequent analysis.

1.2 Impact of Unionization on Wages

Gunderson states that "...there are few studies of union impact (on wages)..." (Gunderson: 1982, p.259.) He then reviews three key studies: Starr, reviewed occupational wage rate data from 1969 and estimated that the union - nonunion wage differential for production workers in Ontario ranges from 10% to 17% , the greater amount being found in heavily organized industries with monopolized product markets; Kumar related wage variation among industries for unskilled workers to a variety of forces, including the "...proportion of employees covered by a collective agreement...(amounting to) 17 to 23 percent"; Christensen and Maki estimated that "...for every increase

of 10 percentage points in the proportion of workers covered by a collective agreement is associated with a 4.2 percent increase for the average production worker"; MacDonald and Evans "...calculate the union - nonunion wage differential as 24.0, 11.3 and 13.6 (percent) for skilled, semi - skilled and unskilled workers respectively, over the period 1971-1976" and they also suggest that "...as the industry becomes more organized nonunion wages rise more rapidly from the 'threat' effect than do union wages from the coverage effect". (Gunderson: 1982, pp.260-261.)

These studies tend to confirm that unionization has a positive effect on wages, so we can see that the therapists' move towards unionization, in search of increased wages, was a logical one. The literature does, however, suggest that there is a 'spill over' effect from unionized groups to nonunionized groups which we may find has some impact on the case of the therapists. The next section discusses the Bilateral Monopoly Theory as a means of understanding the evolution of the therapists from a consultative association to a fully fledged trade union, followed by a description of the model that will guide the subsequent analysis.

1.3 Bilateral Monopoly Theory

The Bilateral Monopoly Theory (BMT) suggests that if both a trade union and an employer are operating as monopolies, a range of potential wage settlements will be established that is either above or below the settlements that would be set in a free labour market, with

the final bargain being determined by the relative bargaining power of the two parties.

Looking at the labour market as a whole, if the employer is a monopsonist, neo-classical labour market theory predicts that the employer will be able to keep wages down. The forces supporting the potentially monopsonist actions of hospitals as employers of paramedical professionals are considerable:

- o options to employment outside public hospitals (i.e., private nursing homes and clinics) are considerably poorer in terms of wages, benefits and working conditions (see section 4.2), except for pharmacists who have numerous private sector options
- o a hierarchy of hospitals gives the employers at the top of the hierarchy additional power because of the relatively greater attractiveness of the jobs they offer (Municipal hospitals, such as the Royal Alexandra Hospital in Edmonton, have traditionally paid higher wages)
- o formation of the AHA (1948) as the representative of all hospitals and the general development of province wide bargaining in the health care industry reduced the opportunities for employees to increase their bargaining power by 'whip-sawing' employers. If employees unionize and become a form of monopoly, wages can be generally expected to be within a range above that which would be set by the free market.

The BMT predicts that if the employer's monopsonist power is greater than the power of the employees, and if it uses that power, wages, and possibly other terms and condistions of employment, will be set at a lower level than the free market would set. As employee bargaining power increases, we should see wages gradually exceeding the free market level. Therefore, if the transformation of therapists' bargaining status, from a consultative association to a fledgling trade union and then a to fully fledged union, operates as one might

expect, improvement in the terms and conditions of employment should accompany a transformation under the BMT. The question to address is, how much of this improvement is due to the power created through bargaining status changes and how much is the result of market or other forces.

1.4 Analytical Model

As was hypothesized in our discussion of the BMT and the impact of unionization on wages, when there is a monopsonist employer, employee salaries (and possibly other benefits as well) should theoretically be higher when there is a union present than when the employer's monopsonist power is unchallenged. Given that the therapists do deal with a somewhat monopsonistic employer in the form of the AHA, and considering that the therapists have experienced three distinct phases in their evolution as a trade union, a model can be developed for the prediction of therapist bargaining results.

The employer hospitals have been monopsonists almost since their inception. The nature of health care in Alberta is public, meaning that if you want to work in this industry as a therapist, you will most likely have to do so in a hospital. As we shall see in Chapter Two, almost all Alberta hospitals offer the same terms and conditions of employment. In recent years, private therapy clinics have offered some options to hospital employment but they still represent a small fraction of the total number of therapists employed. Since the AHA bargains for nearly all hospitals in Alberta, we have clear conditions

of monopsony. (1)

Applying neo-classical labour market theory, we would expect to see wages in hospitals being below what one would expect under free market conditions. With the unionization of therapists, the BMT predicts that therapists' bargaining attainments should improve coincident with their unionization. With this background, it is possible to set forth a model for the prediction of therapists' bargaining attainments. This is a general model which is applied to therapists in Alberta yet it could apply equally well to other therapists in similar situations. Figure 1 below outlines the elements of the model.

FIGURE 1.0

ANALYTICAL MODEL OF THE EVOLUTION OF THERAPISTS BARGAINING STATUS

< PERIOD ZERO >
- o AHA acts for hospital
- o no employee voice
- o salaries below free market level

< PERIOD ONE >
- o therapists become consultative association
- o differential from free market rates reduced

< PERIOD TWO >
- o therapists become fledgling trade union
- o differential from free market rates reduced, possibly exceeding free market rates

< PERIOD THREE >
- o therapists become fully fledged trade union
- o salaries may now exceed free market rates

At each of the three periods in the evolution of the therapists'

unionization, as depicted in the model, we can hypothesize that the therapists' bargaining power and hence their bargaining results should show improvement. As well, we can hypothesize, that as these evolutionary steps are not equal in their effect on bargaining power, their influence on bargaining outcomes will be unequal as well. We cannot measure this increase, but, if it is reflected in the bargaining results, we should see more improvement in bargaining results during each period. In the model we refer to the differences between therapists' wages and benefits and those that would be expected in a free market. Of course we cannot tell what the market rate for therapists' would be, because there is no such rate, but we can compare therapists' results with a comparable group that does have a market rate, like pharmacists, who have considerable employment options both inside and outside of hospitals. We do make comparisons with other hospital groups, but pharmacists are the only group who work in both the public and private sectors. Data for private sector pharmacists is limited, but we will compare the private and public sector rates where we can and extrapolate for other years. We do not suggest that this is a perfect comparision but we believe it to be a reasonable one and the best one available.

Later sections will address the quantitative influences on settlements such as labour supply and demand and price effects. Two factors, considered by labour relations professionals in the hospital industry to have profound effects on settlements, are pattern bargaining or 'me-too-ism' and the salaries of comparable groups. Since nurses are

considered by many practitioners to set the pattern for wages and benefit settlements in hospitals, we shall be looking closely at their movements and how they fit with the movements of therapists. Technicians are also used as a comparison group because they were among the first to unionize in that industry and it was the narrowing of the gap between technicians and professionals that started many professionals thinking of the impact of unionization. Pharmacists are used because they are the largest unionized group that has considerable employment options outside public hospitals. If some monopsony power is being exercised by the hospitals acting through the AHA, therapists should do relatively less well compared to pharmacists, whose settlements should most closely approximate free market rates, until the therapists achieve fully fledged union status. (2)

To test this model we will have to factor out the influences on bargaining gains other than the change in bargaining status, which will be the task undertaken in Chapter Six. But first, we must understand the labour relations structure of the Alberta hospital industry and the factors which influence bargaining outcomes. These issues will be examined in the next two chapters.

FOOTNOTES

(1) Monopsony is a condition where an employer is large enough that his decisions regarding the level of wages to be paid to his employees can influence the general level of wages for the employees in an industry.

(2) Relative wages between two groups like therapists and pharmacists will be largely market driven in either case. However, there could be skill shortages (or excess demand) or the opposite (e.g., excess supply) in each of the sub labour markets of the broader health care market corresponding to each category of employees.

CHAPTER TWO

LABOUR RELATIONS STRUCTURE IN THE ALBERTA HOSPITALS INDUSTRY

2.1 Introduction

To understand the manner in which collective bargaining is carried out in the Alberta hospital industry it is helpful to review the way in which the hospitals and their employees are organized with regard to collective bargaining.

2.2 Alberta Hospitals Organized by Districts

The hospital industry in Alberta is organized as a number of separate hospital districts, where each hospital either comprises part of a larger district or operates independently. For the purposes of collective bargaining, the Board of Industrial Relations (called the Labour Relations Board since 1980) has defined the employer as being the hospital district. Hospitals not part of a district are (themselves) deemed to be the employer. The principal rationale for that decision appears to have been to correct or prevent problems arising where "certification (would be) issued to more than one bargaining agent for identical bargaining units within the same hospital district..." (Alberta Board of Industrial Relations, Bulletin #4, 1976) and to avoid an overly fragmented bargaining structure.

2.3 Employees Organized In Five Units

As a result, the Board's focus for unit determination has relied on the operation of a proposed bargaining unit as it relates to its

'functional' contribution to the employer. These units are as follows:

1) **Professional Nursing Care:** A unit comprised of all employees of the employer providing direct professional nursing care or instruction therein, as evidenced by membership in the Alberta Association of Registered Nurses (A.A.R.N.) or as a graduate of a recognized school of nursing and would encompass all such employees employed by the employer up to and including the level of head nurse or its equivalent.

2) **Auxiliary Nursing Care:** A unit comprised of all employees of the employer providing direct auxiliary nursing care and could include employees classified as certified nursing aides, nursing aides, nursing assistants, registered orderlies, orderlies, ward aides, and operating room technicians.

3) **General Support Services:** A unit comprised of all employees of the employer providing general support activities including those employed in activities such as clerical, office trades, food service, housekeeping, and custodial.

4) **Paramedical Technical:** A unit comprised of all employees of the employer providing qualified technical patient care support services as evidenced by completion of a prescribed course of study and required membership or eligibility for membership in an association or group formed for the purpose of regulating standards of competence in the technical field of activity and, in some cases, employees directly related to such technical services. Examples of employees that would fall into this group are medical record librarians, medical records technicians, remedial gymnasts, radiological technicians, medical laboratory technologists, respiratory technologists, certified combined technicians, dietary technicians, medical photographers, and psychiatric nurses.

5) **Professional Paramedical Support:** A unit comprised of all employees of the employer providing qualified professional paramedical support services as evidenced by university graduation and required membership in an association or group formed for the purpose of regulating standards or competence in the professional field of activity. Examples of employees that would fall into this unit are dieticians, pharmacists, medical social workers, occupational therapists, physiotherapists (who are the focus of this study), laboratory scientists, clinical chemists, and medical psychologists.

During the early 1970's, groups (1) through (4) bargained as separate

units, while group five was split among a number of units. Within the fifth category, pharmacists and therapists bargained independently as did speech pathologists, audiologists and other professional paramedical support personnel.

During the time period examined (1970-1985), all but five of over 200 Alberta hospitals (University of Alberta Hospital, Foothills Provincial General Hospital, Provincial Cancer Hospital, Glenrose Provincial Hospital and the Alberta Provincial General Hospital) bargained under the Labour Relations Act of Alberta. The other five mentioned bargain under the Public Service Employee Relations Act. Nearly all Alberta hospitals, however, were represented in collective bargaining by the Alberta Hospitals Association (AHA).

Most nurses (Professional Nursing Care - Group 1) were represented in bargaining by the United Nurses of Alberta, a trade union, formed in 1976 to replace the A.A.R.N. as the bargaining unit for the nurses. Technicians (Paramedical Technical - Group 4), therapists and pharmacists (Professional Paramedical Support - Group 5) were represented by the Health Sciences Association of Alberta: the latter two groups only since 1979. The therapists commenced bargaining as a consultative association in 1970, becoming a fledgling trade union in 1975 when they gained voluntary recognition, and becoming a fully fledged trade union in 1979 when they joined the HSAA. The pharmacists were a trade union prior to 1979, but a relatively small one.

The remaining health industry employees were represented by either the Alberta Union of Provincial Employees (AUPE) or the Canadian Union of Provincial Employees (CUPE), plus a few independent unions, such as the general support group that broke away from CUPE at the Royal Alexandra hospital in Edmonton.

2.4 Therapists Compared To Three Other Hospital Employee Groups

The therapists, who are the primary focus of this investigation, were represented professionally by either the Association of Chartered Physiotherapists of Alberta (the Alberta College of Physical Therapists since 1986) or the Alberta Association of Registered Occupational Therapists. To provide a basis for comparing therapist bargaining gains vis-a-vis those of other health care industry employee groups, data was compiled on hospital employee groups who both worked for the same employer and who worked under similar conditions as the therapists. The selection was made from among the five major employee units in the Alberta hospital industry, as identified in the above paragraphs, choosing only groups which enjoyed a legal right to strike.

Using these criterion, three key groups were selected and included in the analysis: nurses, the technical unit of the HSAA and pharmacists. Nurses appear to have the strongest strike threat, as they are the only group of the four who have gone out on strike. The pharmacists had a legal right to strike before they joined the HSAA, but their smaller size and no strike history suggests that their strike threat

would not be as strong as that of the nurses. Indeed, if it could be argued that groups like the pharmacists and therapists were carried on the nurse's 'coat-tails', there would be little need for them to exercise any right to strike, weak or otherwise. The paramedical technical unit of the HSAA was also included, but as a control group for professional/non-professional bias (1). The other two units, Auxiliary Nursing Care and General Support Services held little similarity with paramedical technical or professional units and as a result were not used for comparison.

2.5 OTHER COMPARISON GROUPS ADDED

Comparisons among groups within the Alberta Health Care Industry are the most directly relevant, but to provide a broader perspective on developments outside health care in Alberta, comparison will also be made with librarians at the University of Alberta (U of A), and therapists and nurses in selected other Canadian provinces (2). The librarians, whose wages were a bit higher than therapists in 1971 but significantly lower in 1981, were added as a group who would have experienced similar 'environmental conditions' as therapists in Alberta. The therapists from other provinces were added to determine how the Alberta experiences compared to those found elsewhere. As well, comparisons with other appropriate groups are included to broaden our understanding of general trends.

The many factors influencing bargaining power is the topic of the next chapter.

FOOTNOTES

(1) The three groups are all within the umbrella of the HSAA however, the therapists, pharmacists and other paramedical professional personnel are in the 'professional' unit while the technicians are in the 'technical' unit. As each unit is certified separately and has its own agreement for negotiation and ratification, the bargaining structure is changed as one organization bargains for both units and, of course, the professional unit contains more than just therapists.

(2) The 'selection' was based on whether provinces had salary data for the period under study and whether they were willing to share it with us. Representatives of four provincial associations of therapists responded to our survey : Manitoba, Quebec, New Brunswick and Nova Scotia.

CHAPTER THREE

GENERAL INFLUENCES ON BARGAINING OUTCOMES

3.1 Introduction

Before we enter into an analysis of the bargaining activities of therapists we should look at the environment within which they bargain. Chapter Three starts with a discussion of bargaining power as a key force in determining collective bargaining outcomes. From this basis, it proceeds to discuss the measurement of relative bargaining power as an appropriate and practical alternative to the measurement of absolute bargaining power, concluding with a more specific discussion of factors influencing bargaining power and, finally, presents the hypotheses that will be tested in Chapter Six.

3.2 Bargaining Power As A Force In Collective Bargaining

3.2.1 Collective Bargaining Focuses On Competition For Scarce Resources

The process of collective bargaining focuses on the ability of the parties involved to obtain some of what is desired through a form of competition for scarce resources. This joint decision-making process for resolving the often conflicting interests of labour and management establishes terms and conditions of employment, or more specifically wages, hours, benefits and working conditions. While collective bargaining might encompass other subjects, the vast bulk of activity deals with wages, hours, benefits and working conditions. It is in these general areas that achievements in bargaining will be measured.

3.2.2 Bargaining Power Depends On The Ability To Resist

The ability to acquire gains in the context of labour - management relations is manifested through a force known as 'bargaining power' which focuses on "...the ability to win concessions in the face of opposition." (Pen: 1952, p.25) The presence of opposition is significant as bargaining power can only operate when there is some degree of resistance. Without resistance, goal attainment is simply a reflection of 'absolute' rather than 'bargaining' power. The ability to resist is related to the ability to withstand a lawful work stoppage, for a party's bargaining power is significantly affected by its ability to withstand the costs associated with a work stoppage. If there is no opposition there will be no costs, since under these circumstances the obtaining of a benefit is not winning a concession but merely an undisputed acquisition.

If we can liken bargaining power to electricity, we would describe it as being present within a battery ... that is, as a potential. Unless there is some form of resistance, such as a wire or an appliance, there is no flow of electricity. In this instance, bargaining power is the current which flows only when resisted, at all other times it is only a potential. Thus, when there is a lack of resistance, bargaining power is absolute. In the presence of resistance, bargaining power is a 'relative' concept. The key issue then becomes how strong or powerful is one party vis-a-vis its opponent.

3.2.3 Economic Forces Affect Public And Private Sector Differently

The factors that determine bargaining power are many and varied and depend upon the characteristics of the environment and time frame within which the groups operate. In the private sector a prime factor influencing bargaining power is the economic circumstances the parties face. In the public sector, the role of economic factors may become less significant. As Pen states "If the state fixes a wage rate, the power behind the decision is of a political nature and cannot be analyzed by economic science." (Pen: 1952, p.26)

To say that economics is not a factor in public sector bargaining is an oversimplification. Although the profit motive is not necessarily widely present, there is certainly a condition of scarce economic resources, as the many and varied efforts currently being used to reduce government budget deficits testify. If we use the government as an example of a major employer in the labour market, we can see that economic as well as other forces are incorporated within an environment where economics do not necessarily take the lead. As Beal, Wickersham and Kienast (1976) state, for 'essential services,' in particular:

> Public participants in the volatile activities of labour-management relations feel the constraints of political forces more directly than their private sector counter parts, who operate in a comparatively simpler and more stable institutional setting ...lockouts are viewed as impossible ...strikes are particularly effective. They succeed almost in direct proportion to the essentiality of the services the strikes deny the public, for they quickly generate pressure for settlement of the strike from affected citizens on their elected public officials.

As well, the economic impact of a public sector strike typically is much greater for the employees than the employer. In the private sector the economic difficulties created by the strike can be greater for the employer than the employees. For example, the government provides many services for which it does not receive payment from the users of the service. During a strike the government reduces its costs by the amount of the usual wage bill, assuming it does not replace the striking workers. Any 'for profit' business in the private sector would lose money if its operations were halted as a result of a strike, for its operation is premised on the assumption that its revenues exceed its expenses. If the strike stops the revenue, that excess of revenue over expenses is likely to be lessened, if it exists at all.

There are exceptions in the Canadian public sector such as ferries, liquor stores and public transportation, where a strike would affect the income stream, but these are exceptions rather than the rule. As well, with subsidized services such as public transportation, revenue is less than expenses so when work stoppages reduce the wage bill the government can end up saving money.

For public sector employees we can see that the incentive for the employer to settle the dispute in order to restore its profitability is not necessarily present. While this does not say that public sector employers prefer not operating, it does suggest that the public sector

employees cannot use the 'economic distress' lever as effectively as can their private sector counterparts.

3.2.4 Government Intervention Can Affect Bargaining Power

The propensity of government to intervene in essential services disputes can dramatically affect a bargaining unit's chances for a successful strike. The essential nature of many public services has rendered the prospect of work stoppages distasteful to many segments of the public. Public sector employer militance has been manifested and fortified by recent events, such as the mass dismissals in the United States of air traffic controllers engaging in (unlawful) strike activities in violation of their oath of office during 1980.

Still, the point remains that the environment of public sector labour relations differs from that of the private sector. Consequently, the ability to win concessions from an opponent (ie. relative bargaining power) is determined by a wide variety of forces and constraints, at least some of which are somewhat different from those found in the realm of profit making enterprises.

3.2.5 Four Categories Of Factors Affect Bargaining Power

To identify all of the factors which may affect bargaining power in the public sector would be somewhat presumptuous and, perhaps more important, unnecessary, since we seek only to identify the more significant of these influences. Williams (1982) identifies determinants of bargaining power as fitting in four general

categories:

a) knowledge, skill and experience of the principal negotiators and their back-up men;
b) the historical pattern of the particular union-management relationship;
c) the impact (at) the bargaining table of external forces and conditions, economic and political...; and
d) internal pressures operating on both participating parties....

3.2.6 Factors Affect Bargaining Committees In Different Ways

Each of these factors impact bargaining committees in different ways, depending on the particular parties involved. Moreover, they apply to both private and public sector collective bargaining although sometimes in different ways. Public and private sector bargaining alike are affected by the skill and experience of the participants, historical relationships and intra - organizational and inter - organizational dynamics. It is within the influence of external economic and political forces that public sector bargaining power is affected in a manner at least somewhat different from that occurring in the private sector.

Additionally, psychological factors such as "... perceptions, general attitudes, attitudes toward risk, and overall mental fortitude and resolve (i.e., 'true grit')" (Fisher, Bourgeois and Purdy, unpublished) may also be different in the public sector vis a vis that found in the private sector. These factors will comprise part of the considerations when discussing the factors influencing bargaining power in the latter portions of this chapter, but first we must review the concept of relative bargaining power.

3.2.7 Measurement of Relative Bargaining Power

The measurement of bargaining power is a problem that has eluded theorists and practitioners alike. The fact that bargaining operates under uncertainty and that information may be hidden and tactically released, for instance, to alter perceptions, makes it more difficult. If we could measure bargaining power absolutely, it would greatly assist the calculation of bargaining outcomes. Static, plenary measurement of such a dynamic force does not seem to be possible. There is simply no 'power meter.' What can be done though, is to measure how a group's bargaining power stacks up against that of another group in similar, comparable circumstances. This 'relative' measure, however, will not allow us to determine the absolute gains of any one group. In other words, absolute gains are of little value, unless they are compared with the gains of another group. In fact, collective bargaining uses inter - group comparisons so frequently to support bargaining demands that such comparisons of bargaining outcomes may be more useful in assessing which groups have greater bargaining power relative to their counterparts at the bargaining table.

With this background we can now look at the major forces affecting bargaining power.

3.2.8 Seven Factors Influence Bargaining Power

Williams (1982) considered seven factors as most significant

influences on bargaining power:

a) sovereign authority of the government;
b) public opinion;
c) political influence;
d) public emergency legislation;
e) price inelasticity of the service;
f) right to strike; and
g) bargaining structure.

The following section discusses each of these plus one other, the 'psychological' factor, in terms of their impact on the bargaining power of employee groups in the public sector and also attempts to highlight the differing impacts such factors have in the private sector.

3.2.8.1 Sovereign Authority of the Government

Governments Operate As Employers And 'Makers Of The Rules'

In their role as the protector of the people, the governments of Canada and the ten provinces are unique employers. Governments not only negotiate with their employees under the established rules governing public sector labour-management relations but they can both change the rules of the game and repudiate settlements, if they so desire. Hence they can deal with their work force both as employees and 'subjects.'

The government's responsibility to protect the public leaves the legislature with the ultimate decision - making authority on wages and benefits and may remove many issues from collective bargaining. The correspondingly narrower scope of bargaining affects the relative bargaining power of public sector trade unions by reducing their trade

off options, as compared to their private sector counterparts. As well, this 'third party negotiator' in the form of the legislature, is not usually at the bargaining table, so a situation of 'shadow-bargaining' develops (1).

A last consideration is that in a number of instances governments can control funding in a negative, as well as in a positive fashion, thereby also affecting the bargaining power of the employee group. On the one hand, it can restrict the funding of certain public institutions such as universities, thereby exerting considerable influence on outcomes. On the other hand, it can also untie the purse strings and finance whatever settlements are obtained.

The government's unique role as both 'team manager' and 'maker of the rules' impacts public sector bargaining in ways that do not exist in the private sector. In some cases the government constructs 'windows on negotiations' (i.e. the Alberta Hospital Association) where they are not directly involved in the negotiations, but they do exert considerable influence on the outcomes by virtue of their control of hospital funding. (Wetzel and Gallagher: 1984, Pp. 283-313.)

3.2.8.2 Public Opinion

Public Opinion A Strong Influence On Public Sector Bargaining Power

The impact of public opinion on bargaining in general is decidedly more significant in the public sector than in the private sector. While consumers may register their dissatisfaction with a private

sector enterprise by shifting to a substitute product, the general unavailability of a replacement public service or product requires that the dispute in question be settled before the demands of the users can be met. Further, because public sector disputes often have a more wide - spread effect on the populace, the typical reaction to a halt in the flow of services is generally more intense.

In some cases, the feelings of the citizenry at large favour the disputing public employees, as was the case when the postal disruptions in the sixties exposed overall poor wage conditions. It seems that more often the public wants the interrupted service restored and the weight of their discontent is applied against the disputing workers. As a result, government employees do not necessarily have the same ability to shift the pressure to the employer as do their private sector counterparts, resulting in a reduction of employee bargaining power. The exception occurs when governments pay extra compensation to avoid such shut downs. As noted earlier, in some public sector strikes the employer saves on the wage bill during a strike without facing a consequent decline in revenues.

3.2.8.3 Political Influence

Politicization Of Collective Bargaining Process Strongly Influences Bargaining Power

Williams (1982) notes that politicization of the collective bargaining process is perhaps the most significant factor affecting the bargaining power of the parties. He also suggests that the general

absence of an economic 'bottom line' forces the parties to pursue bargaining strategies based on political consequences. Therefore, each tends to concentrate on manipulating the political costs of agreement and disagreement rather than the economic ones. Often a struggle results between 'public interest' as espoused by the employer and 'quality of service' presented by the employee group, particularly in the health services and education fields. Each group clearly seeks public support and, in turn, political support for its 'cause'.

Media Campaigns Can Be Major Tools Of Bargaining Power

Such an approach often serves to shift the determinants of bargaining power away from economic forces. This can thrust the parties into situations where, for example, media campaigns designed to change the costs of agreement/ disagreement for the parties by influencing public opinion, may become major tools of bargaining.

3.2.8.4 Public Emergency Legislation

Public services are often considered 'essential' to the health, safety and security of self and property. This means that withdrawal of these services can result in the issuance of a back-to-work order under the provisions of emergency legislation such as the Public Emergency Tribunal provided for in sections 148-150 of the Alberta Labour Relations Act (Chapter L-1.1 RSA 1980).

Many Occupations Considered Essential

Given the broad statuatory interpretation of 'emergency', the list of those services which cannot be shut down in an emergency often extends beyond the traditional 'essential services' such as hospital, police, fire and fundamental municipal services such as water and sanitation. The list of 'critical' occupations includes transportation, shipping and even postal service, as has been evidenced by actions of both Provincial and Federal government in sending workers back to their jobs. Certain components of the private sector are also affected by emergency legislation (as noted above). It is clear from our listing of occupations that public services are much more extensively affected. The fact that governments consider certain occupations to be more 'essential' than others also is reflected in their statutes. (See, for example, Arthurs, Carter, Glasbeek: 1984.)

Inability To Withdraw One's Services Reduces Bargaining Power

It is clear that statutory provisions restricting the employee's right to withdraw his or her services affects the bargaining power of public sector employees. Their ability to pressure the employer to settle is weakened when 'essential' employees can ot withdraw their services. This designation of 'essential employee ' need not be in the best interests of positive labour relations, but it does serve to mitigate the pressure that can be applied by withdrawing services. Clearly, if enough employees are designated essential, the employer often can continue operation, even if all the non-essential employees go on strike. In the Federal Public Service, individual employees are

designated 'essential' employees. In the Provincial Public Service, the service is designated essential but the effect is similar in both jurisdictions: the right to withdraw one's services is hampered.

Strike Alternative Mechanisms May Confer Greater Bargaining Power

While restrictions in the ability to withdraw one's services reduces bargaining power, the alternatives offered to the strike, namely interest arbitration, may increase the parties' bargaining power in other directions. Morris suggests that employee groups, particularly in the public sector may acquire additional bargaining power via arbitration "...for the unions have little incentive to reach voluntary agreement on wages because an arbitrator will never award less than what management has offered at the bargaining table." (Weiler: 1981.) In the case of therapists whose bargaining may have reached an impasse with the employer there is a good chance that arbitration would improve their position.

'Relative Indispensibility' Or 'Essential Services' A Key Factor

An important element in the 'essentiality' of a service is its 'indispensability'. As mentioned earlier, in the private sector there are usually substitutes for the withdrawn good or service. By contrast, many public sector operations often are the sole suppliers of the service or good. This monopoly situation serves to further 'heat-up' the public reaction to the interruption of service. Thus, the existence of irreplaceability significantly modifies the relative bargaining power by increasing urgency and changing costs of

agreement/disagreement.

The effect is most significant during times of economic upswing when the direction of power shifts towards the employees. But if the employees are 'indispensable', the effect may still be significant during recession when the bargaining power shifts towards employers. (Fisher, Kushner: 1986, p. 27.)

3.2.8.5 Price Inelasticity of the Service

Ponak states that "...public employees have little to fear from an exceptionally rich settlement since the demand for their services is price inelastic" (Ponak: 1982, p. 352.) This assumes that the amount of public service delivered is not greatly affected by competitive forces. In turn, it means that an increase in price will not likely lead to cessation of operations, as it might for the same operation in the private sector. It could have an internal effect as departments within a level of government are in many ways 'competing' for a sizeable piece of the budget. As well, there are indications, such as the influence of declining oil prices on the government budgets in Alberta in 1986, that the public sector may be affected as much as the private sector when budgets drop in response to decreases in the revenue streams.

Effect Of Economic Conditions Including The Laws of Supply and Demand Felt In Public And Private Sectors

Given the presence of a substantial 'public purse,' public services

are somewhat more price inelastic than would be the case in the private sector. It affects the relative bargaining power of the public sector parties for it is difficult for public sector employers to say, "Your wage demands will drive me out of business". This relative insensitivity to price is changing. A public sector dispute may create pressures on politicians that are as serious to the politicians as profit is to the businessman and there does seem to be a greater general willingness by the politicians to take a strong stand against cost increases as Canada struggles out of a recession.

Current economic conditions have modified this situation to the point that the public purse is also seen as having limits. The December 1982 layoff of police, firefighters and water and sanitation employees by the City of Edmonton is but one example. In fact, the trend towards 'privatization' of public services has grown at least in part due to the increasing concern over the cost of those services. All of these factors suggest that while public services are still a priority, 'service at any cost' is being vigorously questionned. Still, as economic conditions are seen as worsening in Alberta in 1986, we are seeing some of the 'cut government costs' attitude, particularly when it affects employment of social support programs. An example is offered by the extensive public criticism of increases social worker case loads, voiced so strongly in the spring of 1986,

when only months before the cry was to reduce government spending. In short, some public sector employees do seem to have some renewed insulation from the strict influences of economic conditions.

3.2.8.6 Right to Strike

Private Sector Employees Generally Have The Right To Strike

The ability to withdraw one's services is considered an important factor in the development and maintenance of bargaining power. Private sector employees have this right, as provided in the Labour Relations Act of Alberta, with the exception of provisions restricting the right to strike during emergencies.

Public Sector Employees' Right To Strike Restricted

In the public sector the situation is quite different as there are a number of circumstances under which employees are denied the right to strike. Of over two hundred hospitals in Alberta, only employees of the five that operate under the Public Service Employee Relations Act (PSERA), plus nurses and other health care employees throughout the province (in the 1983 aftermath of Bill 44), are denied the right to legally withdraw their services. Employees of the Crown in the Right of Alberta who bargain under the PSERA also do not have the right to strike (2). However, employees of enterprises owned totally or by majority by the Alberta Government, such as Alberta Government Telephones, and Pacific Western Airlines (while the Alberta Government

was a major shareholder of that airline), have the right to strike as provided by the Alberta Labour Relations Act and the Canada Labour Code in the latter instance.

Therapists Had No Legal Right To Strike: 1970-1978

It was possible that therapists employed in hospitals operating under the Labour Relations Act of Alberta could enjoy the right to strike. They were not represented by a certified bargaining agent, however, so they could not legally strike during the 1970 - 1978 period. In 1979 they acquired the necessary status through affiliation with the Health Sciences Association of Alberta (HSAA), a certified bargaining agent. This gave them a legal, but not necessarily a practical, strike threat.

Legal Authority To Strike Does Not Ensure Practical Ability To Strike

The question of legal versus practical strike threat is germane. Generally speaking, relative bargaining power will be augmented more by a threatened strike from a group that has shown its seriousness by striking in the past, than it would be from a group with no strike history. A possible exception would be when a unit has become relatively indispensible for the first time.

To possess the ability to strike when history has shown it very unlikely to be used does little to enhance the strength of the strike threat. As indicated later in this thesis, therapists consider themselves very unlikely strikers (3). This unwillingness to use the

threat of strike as a key bargaining tool provided much of the motivation for paramedical professionals to seek a separate division within the HSAA during 1978.

3.2.8.7 Bargaining Structure

The manner in which an industry's bargaining units are structured does much to direct the nature of bargaining within the industry. For example, a single industry-wide bargaining unit will provide a more comprehensive approach to negotiations than will a situation of unit multiplicity. With one bargaining agent representing a group of similar employees across the province, the one bargaining agent can deal with all unionized companies employing that type of worker. Thus they get locked into a certain structure and pattern of settlements.

Paramedical Professional Support and Paramedical Technical Units Of HSAA Combined

In 1978, a combination of the Professional Paramedical Support unit (see Appendix A for the list of members in this group) with the Paramedical Technical Unit changed the bargaining structure within the health industry. Each unit negotiates separate agreements, but they both are divisions of the HSAA, the certified bargaining agent. As a result of this combination, the therapists (who were the major component of the Paramedical Professional Support unit) obtained the legal right to strike.

3.2.8.8 Psychological Factors

Fisher, et al.(1986) suggests that, because of the uncertainty involved in collective bargaining negotiations, psychologial factors such as perceptions, expectations and attitudes can play a key role in negotiations. For example, if we accept that the therapists cannot strike legally or practically, or that they do not have access to interest arbitration, either voluntary or compulsary, then the therapists probably would reduce their compensation package objectives and their expectations of what they can achieve at the bargaining table. While the public sector may affect the degree to which the psychological factors affect bargaining, these forces operate in both the private and public sectors in similar ways.

Factors Applying to Therapists

Of the eight factors influencing bargaining power discussed above, supply and demand (the price elasticity of the service), bargaining structure, and sanction access have the most influence on the bargaining results of the therapists. Sovereign authority of the government, public opinion, political influence and public emergency legislation have influence, but it is not specific to therapists. On the one hand, since physical and occupational therapy is often an elective procedure, it is more easily replaced than nursing. As a result, the unavailability of therapist services would be unlikely to cause public emergency legislation to be invoked, except possibly for situations where therapists were combined in bargaining units with other hospital employees. The existence of private therapy clinics reduces the essentiality issue even further. On the other hand, the

need for rehabilitative services offered by therapists is significant even if the absence of that service is unlikely to lead to life threatening situations.

It is clear that bargaining structure could have a dramatic impact on bargaining power, not only as a result of size but also because combination can involve some greater measure of essentiality and indispensibility. Even the most discretionary treatment can become essential if it is inexorably linked with critical care activities. For example, even though therapy is an elective procedure, as noted above, if therapists were to withdraw services along with the rest of the paramedical unit, the collection of services would increase the indispensibility of every group's own services.

The right to strike, as well, has been impacted by the change in bargaining structure. Since 1979, the therapists have belonged to a bargaining unit represented by a certified bargaining agent, so they do have a legal right to strike. If the combination of therapists with other health industry employees provides a positive force in bargaining gains, we should see some indication of improvement in the terms and conditions of employment.

The key question to be answered, however, is what specific impact has bargaining status had on the bargaining gains of therapists. Hopefully, testing of the hypotheses outined in Chapter Five will offer some insight into these questions.

3.3 Economic (Market) Factors

Fisher, et al. (1986) suggests that there are a number of 'key indicators' of the economic forces operating within the bargaining environment that affect bargaining outcomes, namely: "recently negotiated settlements for comparable employees ('package comparators'), the Consumer Price Index (CPI), the unemployment rate, the organization's profit rate ('ability to pay'), and the productivity of the bargaining unit (e.g., unit labour costs). Other economic factors are 'sanction impact influences' (i.e. the expected strike or arbitration costs, strike funds, strike insurance schemes, strike assistance from sister organizations and lines of credit with banks, inventories, alternate sources of supply or delivery, bargaining unit members' savings, the amount of liquid capital available to the firm, and the degree of financial stress). Additional economic factors are 'labour market conditions' (i.e. the number and duration of vacancies, the number of qualified applicants per vacant position and turnover rates) and 'strike data' (i.e. the number and duration of strikes involving the parties at hand and others, especially in the same industry). (Fisher,et al. 1986, p.10-11.) Not all of these factors can be directly related to therapists, but Chapter Six addresses many of them.

In the public sector some of these influences, such as the 'ability to pay', are commonly viewed in a private sector context, but have application in the public sector as well as evidenced by taxpayer revolts (a la Proposition 13 in the U.S.A. and government fiscal

restraint programs). For others there is little if any difference between the private and public sectors. The nature and extent of the influences may vary but the affect on bargaining outcomes is similar. The following sections look at each 'group' of influences and discusses their application to therapists.

3.3.1 Package Comparators

> The market, the relationship between the supply of and demand for the services of a particular occupational group, is the most important variable operating to determine the salary level of any given occupational group. The factors affecting the market are many and those affecting the market for one occupational group are different from those affecting the market for another occupational group. (APEGGA: 1986)

Since we cannot separate all of these factors individually, we use 'package comparators' to indicate the impact of market factors on different groups.

When trying to identify the salary performance of therapists we initially considered a 'single market' approach (only one factor is considered: the salaries paid by similar companies to the occupational group being studied) but we opted for the 'multiple market' approach (the salaries of a variety of occupational groups as well as the trends in these are considered). While a multiple market approach is much more complicated and open to more conflicting results than is a single market approach, we felt that it would be the more useful method. Since our primary goal is to factor out as many influences on bargaining outcomes other than bargaining status as possible, we felt that going beyond the hospital industry and the boundaries of Alberta

for comparisons was essential.

3.3.2. Price Effects

Inflation has played a key role in the determination of bargaining outcomes during the 1970 - 1985 period. In the early seventies, salary increases were often tied to the year to year changes in the Consumer Price Index and in 1975 the Anti-Inflation Board was formed to put downward pressure on incomes (salaries) in an attempt to control inflation. More recently, the relatively low rate of inflation has been a factor in the moderate salary gains being achieved in many sectors, including the hospital industry and we feel it has been a factor in therapists' bargaining outcomes. Chapter Six provides further details on the relationship between price effects and bargaining outcomes.

3.3.3 Labour Market Forces

A third important influence on bargaining outcomes is the nature and extent of the labour supply and demand situation. Job vacancies, unemployment and turnover rates all affect bargaining outcomes as the collective bargaining process recognizes and responds to the relative tightness or slack in the market. Section 3.3.1 discussed the influence of salaries in comparable occupations but we must not neglect the structural influences that contribute to the determination of these salary levels. We have collected data in all three of these areas for therapists, albeit with some gaps, to see if there is a relationship between bargaining outcomes and labour market forces for

therapists.

3.3.4. Sanction Impact Influences

The volatile nature of hospital industry bargaining in the late 1970's and early 1980's has brought the impact of strikes and subsequently interest arbitration into the foreground of labour relations in that industry. Previously a relatively quiet labour relations environment, the next chapter discusses how the industry has evolved from a 'Florence Nightingale' attitude to one more akin to the traditional unionized labour attitude. We have identified the major strikes in the Alberta hospital industry to try to determine if there is a relationship between these strikes and therapists bargaining outcomes.

3.4 Situational Factors

Although the economic environment has considerable influence on bargaining outcomes, there are many powerful, non- economic, 'situational' factors that exert considerable influence on bargaining outcomes. Fisher (Fisher, et al. 1986.) states that "situational factors include legislation regulating or applicable to the negotiation process: the history of negotiations between the parties; the past administration of their agreements; the sector (i.e. public v. private); the nature of the industry (including the kind of product--i.e., perishables versus durables--and the kind of production or service delivery cycle); the number and location of relatively indispensible employees; political constraints (both within and outside the organization); the demographics of the bargaining unit

(i.e. age, sex, education, skill levels, and job classifications); economic (i.e. competitive) constraints; the bargaining structure (i.e. multiple parties or single party on either side of the bargaining table); the extent to which negotiations are pattern-setting or pattern-following; the nature of the union-management relationship (i.e. conflictual v. cooperative), the stage of negotiations (i.e. first agreement v. renewal); previously prevailing terms and conditions of employment; negotiating experience (especially of chief negotiators); the kinds of issues involved; earnings and bill payments arrangement (especially during a strike); proposed strike or lockout management schemes (for maintaining and boosting morale); the type of public support system (i.e. unemployment insurance or universal health care and the system's impact on the scope of bargaining) and the amount of information available for decision making." Chapter Four relates many of these factors to the situation of therapists in the context of hospital industry bargaining.

3.5 Organizational Factors

"Organizational factors include organizational goals, structure and administrative policies (i.e. union or corporate policies). Two 'technical' factors are the organization's capital to labour ratio and the degree to which chains of production, distribution of service delivery are automated." (Fisher, et al. 1986, Pp.11-12) Many of these situational and organizational factors have been discussed in earlier sections while others are addressed in the following chapters.

The key situational factors yet to be discussed are the history of negotiations in the Alberta hospital industry and pattern - setting/following (see Chapters Four and Six). On the organizational side, organizational priorities and demographics, in particular as they relate to therapists' bargaining, will be discussed in Chapter Six.

FOOTNOTES

(1) 'Shadow Bargaining' can be described as a situation wherein a party with final decision-making authority is not present at the bargaining table. Such a situation changes the complexion of the negotiations as the negotiators cannot use their skills and abilities to directly influence the absent party by virtue of that very absence from the interaction of face-to-face bargaining.

(2) The hospitals under the PSERA are: The University of Alberta Hospital, The Foothills Provincial General Hospital, The Provincial Cancer Hospital, Glenrose Provincial Hospital and Alberta Provincial Children's General Hospital.

(3) The author was advised a number of times in conversations with the therapists both prior to and during negotiations, that the membership of the therapist groups did not want to strike. In fact, the bargaining committee was instructed by the membership to push for gains but to stop short of going on strike to achieve gains.

CHAPTER FOUR

THE ENVIRONMENT AND HOSPITAL INDUSTRY BARGAINING IN ALBERTA

4.1 The General Environment in Alberta

4.1.1 Introduction

Before we look at detailed bargaining results and attempt to assess how and by what factors these results were influenced, it is helpful to review the general environment within which this bargaining was taking place. The next section describes the general economic and labour relations environment in Alberta during the 1970 - 1985 period (much of the data on this topic was obtained from the annual reports of Alberta Treasury) and includes comments on demographic shifts, inflation, government controls and the National Energy Policy, as well as numerous other factors.

This is followed by a history of bargaining in Alberta hospitals. The last section then goes on to detail specifics of the negotiated agreements for therapists and other groups and closes with a discussion of price effects, labour market data and sanction impacts.

4.1.2 The Alberta Scene

The Early 1970's

Alberta's economy experienced rapid and substantial expansion in the early 1970's. Yet rapid growth in the labour force combined with a lag in business recovery to produce a significant level of unemployment (1971 - 5.7%, 1972 - 5.6%) and inflationary pressures continued to

affect prices. By 1973 Alberta's economic performance improved considerably and in 1974 the province recorded what has been considered its first 'boom' year. Alberta recorded record increases in job creation and employment growth and the relatively rapidescalation of energy prices fueled the province's economy.

The Mid and Late 1970's

Despite economic problems on the national and international scene, the Alberta economy showed only a moderate slowing of real growth. Housing starts rebounded after 3 consecutive years of decline, growing by 30% in 1975. 1975 also saw wages and salaries increase by 22%, well above the national level, andin - migration was up more than 150% over 1974. In response to the continuing high rates of inflation in Alberta and in the rest of the country, the Anti-Inflation Board (AIB) was created in 1975 to put downward pressure on incomes and prices. The AIB was a federal body but "... the Province of Alberta entered into an agreement with the Government of Canada for the application of the federal Anti-Inflation Act and national guidelines to the public sector until March 1977." (Reid:1987) With this agreement all collective agreements in Alberta would be reviewed and monitored by the AIB.

Annual wage increases in the Canada during the mid 1970's were almost double those negotiated in the U.S. creating problems for Canada's balance of payments due to the unrealistic demands being placed on the economic system. 1976 and 1977 saw the depreciation of the Canadian

dollar by more than 10% compared to the U.S. dollar. Production levels dropped and some industries experienced layoff.

In 1978, the depreciation of the Canadian dollar continued, aiding exporters, but increasing general costs on imported goods, leading to increased deficits in the balance of payments.

The Bank of Canada increased its lending rate several times throughout the year, reaching a record level of 11 1/4%. Investment growth slowed and public wage guidelines were set at 6 - 7 1/2% by the Alberta government. Net migration remained high with close to 3000 persons arriving in the province each month. Rapid job creation continued and cutbacks in the Iranian production of oil led to increases in domestic production.

In 1979, most of the world was threatened with an oil shortage. Although Canada had a huge energy potential it faced one of the world's largest per capital balance of payments deficits. Albertans faced high interest and inflation rates and housing starts began to decline. The province agreed to restrain government expenditures and set a wage and salary guideline of 7.5 - 9%.

The 1980's

The slowing of economic growth in the West, the result of high interest rates and declining oil prices, began to affect the entire economy. Unemployment began to rise, and employment opportunities

shrank as inflation continued its upward spiral.

The Canadian economy fared poorly in 1981: the national inflation rate reached a 33 year high, unemployment surged to record levels and high interest rates burdened Canadians. Yet in spite of all these negative signals, Alberta still managed a 4.5% increase in its real gross domestic product and investments increased by 22%. Average weekly earning rose 14.4%, the CPI increased by 12.9% and 61,000 new jobs were created.

The Alberta and Canadian governments signed an agreement on September 1, 1981 which established royalty, taxation and pricing systems for oil and gas and a higher pricing schedule for gas and oil. Oil and gas drilling declined significantly in 1981.

The general economic downturn in 1982 sharply curtailed the demand for many basic Alberta products including oil, natural gas and grains. The province's economy followed the U.S. trend of declining levels of jobs, wages and profits.

Allen Ponak (1985) described the Alberta Industrial Relations environment in the early 1980's at the 33rd Annual Conference on Industrial Relations at McGill University in April 1985.

> Alberta GDP, which grew at more than 5% annually through 1981, fell by more than 4% in 1982 and a further 2% in 1983...unemployment rate tripled in the space of 2 years...far more people left the province in 83 and 84 than entered it...the construction scene collapsed...housing starts went from more than 30,000 in 1981 to

> less than 3000 in 1984...negotiated wage increases fell (i.e. 1982 averaged 13%, 1984 averaged 4.5%, 1985 averaged 1%)...in 1984 almost 1/2 of employees under collective agreements received no wage increase...work stoppages fell sharply...1980-82 strikes consumed approximately 350,000 days per year, in 1983 and 1984, combined lost days was approximately 100,000. (Ponak: 1985).

As Ponak summarized the events of the 1982 - 1984 period,

> the economy collapsed...the most dramatic developments were in the two most highly unionized sectors of construction and the public sector...in construction, union construction virtually disappeared and a brand new employer tactic, the one day lockout, emerged (after agreement expires employees are locked out for 24 hours, thereby breaking the contract, and are then invited back at lower wages)...much of what happened in the public sector in 1983 and 1984 was triggered by the 1982 round of negotiations which were marked by a bitter province-wide nurses strike..but even more significant was the fact that the wage settlements proved far too generous for the deep recession the province was entering. (Ponak: 1985).

In 1983, the government of Alberta passed Bill 44 which removed the right to strike from hospital workers and replaced it with binding arbitration, requiring arbitrators to take into account the fiscal policies of the government when deciding on public sector wage settlements.

By 1985 the economy was starting to recover but the rapid decline in oil prices had again curtailed recovery. With the improved standing of the New Democrat and Liberal parties in Alberta politics, 1986 and the following years promise to be interesting times in the labour relations environment as employees and employers alike try to adjust to the environment. The next section moves our discussion from the broad provincial scope to the more specific circumstances of the Alberta Hospital Industry.

4.2 UNIONIZATION AND COLLECTIVE BARGAINING IN ALBERTA HOSPITALS FROM 1912

Unionization in Alberta hospitals started in 1912 with the voluntary recognition of the Canadion Union Of Public Employees (CUPE) at the Calgary General hospital. As a municipally funded hospital, the Calgary General was uncertain if their employees were part of the civic employees union, so they voluntarily recognized the hospital service workers. A similar situation occurred at the Royal Alexandra Hospital in Edmonton, another municipally funded hospital, and the precedent for unionization of hospital workers in Alberta was firmly established.

Not long afterwards, the Service Employees International Union (SEIU) (later to be absorbed by CUPE), was recognized as the bargaining agent for service workers in the General Hospital in Edmonton and the Holy Cross Hospital in Calgary; both hospitals were operated by the Catholic church.

War Conditions Accelerate Unionization

In 1942, labour peace was sought, yet conditions supported the rapid unionization of hospital service workers. By the post war depression, bilateral negotiations were in vogue, but groups like the Alberta Association of Registered Nurses (AARN) were unsure whether they were a professional licencing association or a trade union, a dilemma which was also faced by other quasi-professional groups including

dieticians, pharmacists and therapists.

Pressure Mounts For Bi-Lateral Negotiations

By 1974, so many groups were seeking bi - lateral negotiations that it appeared that the employer would have to deal with too many groups. So the Board of Industrial Relations designated five employee groups within the hospital industry. The bilateral negotiations worked satisfactorily as long as both parties were in agreement, but there was no means of enforcing interest disputes. That year, things finally came to a head as the Alberta Hospital Association (AHA) and the Alberta Association of Registered Nurses (AARN) gave different recommendations to their respective constituents. This conflict led the nurses to form the staff nurse division of the AARN in 1975, with the duty to negotiate the terms and conditions of employment for nurses in the form of a traditional collective agreement. This changed the entire context of bargaining in the hospital industry.

Neither Nurses Nor Therapists Have Authority To Conclude A Collective Agreement

The problem with these attempts to negotiate formal collective agreements was that neither of the bargaining parties had the legal right to enter into a collective agreement. The AHA could negotiate on behalf of its member hospitals and the AARN on behalf of nurses, but only the hospitals and the individual local of the AARN could conclude a collective agreement. The therapists had the identical problem as neither the therapists' association or the AHA had status under the

Alberta Labour Act to sign a collective agreement. This worked well as long as the parties honoured each other's positions, but the arrangement quickly broke down when disputes arose. Only the ethics of the parties or civil litigation could be used to enforce any negotiated terms and conditions of employment. Thus, even though the therapists had a recognition clause in their 1975 agreement, it would not have held up if tested in court. This is why the therapists were refused conciliation services in 1978 — they had no status under the labour act.

United Nurses of Alberta Formed To Handle Negotiations-First Strikes Follow

To solve these problems of status, the United Nurses of Alberta was formed in 1976 to operate as a fully fledged bargaining agent for nurses in Alberta. One year later, in 1977, the nurses went out on strike for the first time in their history. Strikes followed in 1980 and 1982 and it was not until 1984 that an agreement was again achieved without a strike.

Nurse's Example Whets Appetite of Other Hospital Groups

Now that the nurses had full bargaining status, other medical groups wanted the same access to influence, for they were seeing a steady decline in their position relative to the nurses, as shown by the following example:

> In the early 1970's, medical laboratory technicians were paid generally the same amount as nurses. Therapists were at the same general level and some specialists like speech pathologists as well

> as pharmacists were paid better. This relationship had been maintained for some years but as soon as the nurses gained their new bargaining structure they started to push for a larger piece of the pie. Because only the nurses were unionized at this point, they achieved gains at the expense of the other groups. (Pedden:1986)

As a result, these other groups started looking at unionization as the only effective means of restoring their historical relationship with the nurses.

Several Factors Influence Bargaining Results of Alberta Hospital Industry Employees

Going back to the early 1970's we can look at some of the major factors that likely influenced the salary gains of hospital employees within the above described framework. These significant influences are noted in point form below:

1) The Alberta Union Of Public Employees went on strike in 1974 and gained an immediate $75 per month for every employee as well as substantial general wage increase three months later. Hospital workers received the same increase, except they also received $100 as the AHA did not want to take any chance that they would be following the lead of the provincial government. This $100 coupled with the gains in the subsequent collective agreement resulted in a significant improvement in salaries in a relatively short time.

2) In 1978 the Anti-Inflation Board (AIB) set a 6% limit on wage increases in Canada. The nurses went out on strike, the Alberta government exempted them from AIB guidelines and they were awarded a 9% increase by Judge Bowen in arbitration.

3) In 1980, the Health Sciences Association of Alberta (HSAA) were ready to settle for an increase of 8 3/4%, but while deliberating the nurses went on strike, ultimately receiving a 17% increase in salary plus a CPI adjustment in arbitrator Lefsrud's arbitration award. Even though over half of the HSAA members voted to accept the 8 3/4% increase, the HSAA held out and received 10% along with an agreement stating that they would receive an adjustment in the following year which would account for inflation and would bring them back in line with the nurses.

4) In 1982, Judge Forsythe awarded the nurses a 20% increase plus a

COLA adjustment in the next year and the HSAA followed along.

Nurses Established As A Pattern Setting Group

These occurrences demonstrate both the power of the nurses and the relationship between the nurses and other groups. Even though the collective agreements of UNA and the HSAA expire at the same time (December 31) the AHA tries to get technicians to settle first, while the technicians try to stall until the nurses settle so they can use their lead to improve their own situation. Nurses generally start negotiating in October and the HSAA in November which is a deliberate attempt to allow the nurses to set the trends (Interview with Ms. Kay Willekes, Executive Director, HSAA, July 1986) The AHA tries to avoid situations like the one in 1980 when the nurses got a rich settlement and their 'leader' position meant that high settlements for the other groups was almost a certainty. The unions, on the other hand, try to arrange just such situations.

In the early 1970's the other groups, including the therapists, were starting to fall behind the settlement of the nurses. With unionization, however, their situation improved. The attitude of the employer was that,

> ...if the therapists had not joined the HSA they would have been very unlikely to receive the large increases that they did. Rather, they would have been left on that downward trend as the more powerful nurses grabbed more and more of the available resources. (Interview with John Pedden, Director of Labour Relations, Alberta Hospital Association, May 1986).

The issue here also regards whether or not the employer would have been compelled to maintain the relationship between the nurses and

therapists, even in the absence of the therapists becoming unionized. To explore this issue we must identify which factors have contributed most to the maintenance of the therapist/nurse relationship in the past and try to determine whether or not those factors continue to be the key influences in the relationship, which is the topic of the next chapters.

CHAPTER FIVE

METHODOLOGY

5.1 Introduction

Now that we have described the general environment of Alberta as well as the more specific environment of the Alberta hospital industry, we have an idea of the conditions within which therapists and comparable groups have conducted their negotiations. From this point, it is appropriate to analyze the specific bargaining outcomes of therapists and other groups and to test the central hypotheses of this thesis.

We shall be looking at two groups of employees, those we call the 'core group' (therapists, nurses, pharmacists and technicians in Alberta) and the 'comparator group' (nurses, therapists in other provinces as well as librarians, engineers and others in Alberta). We shall start with an identification of sixteen bargaining items, selected from therapists' collective agreements that we considered most readily measureable. We shall then review each bargaining item and exclude those for which we find little or no difference in bargaining attainments among the four members of the 'core group'. In addition, we also seek in this chapter to investigate how the bargaining gains of therapists compared to other group's bargaining under similar conditions.

To determine the value of gains we have measured their cost to the employer. The use of cost to the employer raises a number of problems.

It is possible to measure the total cost of an agreement, but the data we would need, in particular the number of employees affected by each collective agreement, were unavailable. Instead, we have looked at the cost of individual bargaining items.

This approach does contain an element of risk in that some agreements may have more psychic or other unmeasureable benefits than others. Psychic gains to bargaining unit members clearly cannot be measured, so we have confined our measurement to economic items that can be easily measured. Since that includes wages, which provides a primary indication of movement in bargaining gains, the exclusion of the 'soft' or 'language' items should not materially affect our conclusions. For example, the therapists managed to change some of the wording in the agreement with the employer to clarify the professional nature of physical and occupational therapy (professional role). While these changes were apparently important to the therapists, they could neither be quantified nor compared to any activities of the nurses, pharmacists or technicians as the collective agreements of these three groups made no mention of professional role. Hibberd (1986) indicates that nurses were concerned over their professional role but as yet they have been unable to include professional role issues in their collective agreements.

5.2 Hypotheses

The discussions in the previous chapters lead us to offer two hypotheses for consideration:

1) The settlement patterns established by the nurses were the most significant influences on the bargaining results of therapists.

2) Major increases in the bargaining gains of therapists in 1975 and 1980 were primarily the result of the change in bargaining status from a consultative association to a fledgling trade union (1975) and from a fledgling trade union to a fully fledged trade union (1980).

The rest of this thesis focuses on the collection and analysis of information necessary to test these two hypotheses. Support of the first hypothesis will indicate whether nurses acted as pattern setters. If the second hypothesis is accepted, it will suggest that the considerable efforts expended by the therapists in becoming a fully fledged trade union were worthwhile. If rejected, it may suggest that those efforts were of little value.

Hypothesis 2 is the central issue of this thesis, and is derived from the analytical model, first discussed in section 1.4, which is reproduced here as Figure 5.0. As we are now applying the model specifically to Alberta therapists, we have included the dates corresponding to each period as part of the model.

FIGURE 5.0

ANALYTICAL MODEL

PRE - 1970: < PERIOD ZERO >
- o AHA acts for hospital
- o no employee voice
- o salaries below free market level

1970 - 1974: < PERIOD ONE >
- o therapists become consultative association
- o differential from free market rates reduced

1975 - 1978: < PERIOD TWO >
- o therapists become fledgling trade union
- o differential from free market rates reduced, possibly exceeding free market rates

1979 + : < PERIOD THREE >
- o therapists become fully fledged trade union
- o salaries may now exceed free market rates

If the model indicates the direction of the salary attainments of therapists (we do not expect it to predict precise salary levels), we would expect to see major increases in salaries during periods two and three, beyond what can be explained by other factors. The data show that therapists salaries increased 40% and 23%, in 1975 and 1980 respectively, which coincides with the changes in their bargaining status. But before we can conclude that the analytical model accurately predicts therapists bargaining outcomes, we must determine what other factors may have contributed to these changes.

The general approach of our analysis will be to first look at the influence that nurses have on bargaining outcomes in the hospital industry. As Hypothesis 1 indicates, we suspect that their position as the largest and most militant of the groups studied may be

significant, and that they act as pattern setters in bargaining relationships. Then, in chapter 6, we look at the factors influencing therapists' bargaining outcomes, the relationship between the therapists' and the nurses' bargaining outcomes and assess the factors influencing the changes in their relative bargaining outcomes. The next section describes, in detail the bargaining items considered and the methods used in measuring gains for each bargaining item.

5.3 Data and Sources

The data for this thesis was compiled from six major sources:

(1) Collective Agreements for nurses, technicians, pharmacists and therapists [1971-1985],

(2) Interviews with bargaining committees for the above four groups [1977-78],

(3) Notes from proceedings of negotiations between therapists and the HSA [1977-78],

(4) Results of a questionnaire on bargaining priorities given to all therapists [1978], (See Appendix B)

(5) Responses to a questionnaire sent to therapy groups in all Canadian provinces,

(6) Research material on the bargaining results of other employee groups both within Alberta and elsewhere in Canada.

Quantitative data from source (1) serves as the foundation of the analysis. The collective agreements of the nurses, therapists, pharmacists and technicians were reviewed in detail and the actual bargaining achievements for each of the bargaining items selected for analysis were compiled (see next section for detailed description of bargaining items).

The results of source (4) provides information on the preferences and goals of the therapists. The questionnaire asked the therapist respondents to indicate the importance of each of twenty-one bargaining items. Based on these responses the bargaining items were sorted in priority from highest to lowest and this information was used to guide the activities of the bargaining committee in the 1978 negotiations. (See Appendix B for a sample of the questionnaire)

Sources (2) and (3), while not providing much quantitative data, have helped the author understand the therapist unit and provide background for identifying and developing the bargaining items to be considered. Accordingly, they will be of assistance in the interpretation of the results for those items. Source (5) has allowed us to develop a picture of the salary movements of therapists beyond the borders of Alberta and the last source (6), allows us to make comparisons outside the hospital industry.

5.4 Bargaining Items Considered

Our initial review of the bargaining items suggested that we could quantify sixteen bargaining items. Many of the bargaining items considered were not directly comparable across groups. To adjust for the differences in contract language and methods of calculating benefits, factors were developed, as follows:

1. Pay for on-call

Until 1980, all groups were paid a flat rate for being on-call during a period of not less than 8 and not more than 24 hours. In 1980, Nurses negotiated an on-call rate that increased for every 8 hours on call between 8 and 24 hours per on-call event. As most on-call duty was from one shift to the next (about 16 hours) we divided the flat rate by 16 to get an average hourly amount that could be compared among groups. One would need to know the number of hours worked 'on-call' to have a more accurate costing, but these data unfortunately were unavailable.

2. Mileage (amount paid for use of personal car to travel to on-call duty)

Expressed in cents per kilometer.

3. Notice of Layoff

Some contracts specify notice on a calendar day basis while others used working days. To standardize we used working days, considering 7 calendar days equal to five working days. For example, a two week notice of layoff provision was considered to mean ten working days.

4. Relief Duties

Whenever an employee is required to fill the spot of another employee who is in a higher paid position the employee that is doing the relieving is entitled to be paid at the rate of the higher position. Provisions regarding the calculation of the amount to be paid above the employee's regular wage vary but generally the additional increment reflects the difference between the regular rate of the lower position and the regular rate of the higher position. The sooner the higher rate becomes due the better for the employee. Consequently, the factor used for this item is the reciprocal of the number of days of work at the higher position required before the higher wage is paid. For example, a person qualified for 'relief duties' pay after fourteen days is better off than one having to work twenty-one days in the higher position before being entitled to the higher pay. The factor for the first employee would be 1/14 while it would be 1/21 for the second.

5. Paid Vacation

The measure of paid vacation is the number of weeks of paid vacation divided by the number of years of service that it takes to qualify for the vacation. The formula is the number of weeks vacation divided by the number of years of service required to qualify for that vacation. A person getting four weeks vacation

after eighteen years of service is better off than one who had to work for twenty years to qualify for the same amount of vacation.

There are at least two steps that an employee typically moves through. (Recent contracts include a third step). The first step is the initial year of employment. In all agreements reviewed, employees were entitled to three weeks vacation after the first year of service. The next step comes after four or five years. It entitles the employee to four weeks vacation. When there is a third step it adds another week after 18 to 20 years of service. By dividing number of weeks vacation by number of years to qualify, for each step, and summing we get factors ranging from Ø.8 to 1.67. The figure Ø.8 represents four weeks after five years, so 1.3 for example, would represent four weeks after four years plus five weeks after 18 years plus 6 weeks after 25 years (4/5 + 5/8 + 6/25 = 1.3)

6. Shift Differential

The members of all four groups are paid for work on shifts where the majority of the hours of such shift fall within the period of 15ØØ to Ø7ØØ hours. The measure used for comparing the shift differentials is the cents per hour of the premium.

7. Salaries

To ensure the most applicable comparisons we used starting level rates; Nurses with BSc's, Therapists with degrees, Pharmacists with degrees and Laboratory Technicians. There were no education based differentials mentioned for the technicians. In this way we were measuring progress of similarly trained Nurses, Therapists and Pharmacists. For Technicians, education was not a variable. The measure generally used is year to year percentage change, except as otherwise noted.

8. Hours of Work

All groups are on 7 3/4-hour work days. The work week may be reduced to 5, 7-hour days eventually but it does not appear to be a priority. If it does come, it is expected that a powerful group, like nurses, will force the change, and the less powerful groups will then get the reduced work week more easily than would be the case if they had to set the precedent themselves.

9. Named Holidays

All groups are paid for ten named holidays per year. The were no provisions for 'floaters' in the agreements reviewed. [Floaters are days that an employee can usually take as holidays at a time of his or her preference, for example birthdays]

10. Health Benefits

Fifty percent of Alberta Health Care and Blue Cross premiums are paid by the employer for all four groups.

11. Sick Leave

Sick leave provisions for all groups were identical during the period under investigation.

12. Overtime

Employees of all groups were paid one and one-half times their regular rate for any overtime hours worked.

13. Term of Agreement

Most groups have two year collective agreements, although nurses had two year agreements before the others. While there possibly is some impact resulting from the length of agreement, the author could not develop an appropriate measure. Moreover, since the industry appears now to be standardized at two years, the impact is considered to be minimal.

14. Educational Leave

All contracts make mention of educational leave as a potential activity. We were unable to determine the extent of use by each in any group and, as such, could not measure the impact of this item.

15. Sole Charge

Premium pay for work as a "Sole Charge" (Nurse in charge of a ward) is indeed a particular kind of benefit. It is, however, specific to Nurses and as such, the comparative benefits of any change in this item could not be determined.

16. Professional Role

Only Therapists seemed to seek a specific clause concerning their role in determination of the nature and extent of patient care. Other groups were undoubtedly also concerned about this item, but their contracts made no mention of it, so that comparisons were not possible.

When each of the sixteen bargaining items were reviewed in detail it was concluded that only seven could be adequately measured and

were appropriate for further analysis:

- o Pay for on-call
- o Mileage
- o Notice of layoff
- o Relief duties
- o Paid Vacation
- o Shift Differential
- o Salaries

In five of these sixteen areas, the provisions found in the collective agreements of each group were identical. A further four items were not measured as they were not uniformly included in the four agreements. Table 5.1 below summarizes the bargaining items included and excluded from further review.

TABLE 5.1

BARGAINING ITEMS CONSIDERED

MEASURED	SAME FOR ALL GROUPS	NOT MEASURED
Pay for On-call	Hours of Work	Term of Agreement
Mileage	Named Holidays	Educational Leave
Notice of Lay-off	Health Benefits	Sole Charge
Relief Duties	Sick Leave	Professional Role
Paid Vacation	Overtime	
Shift Differential		
Salaries		

The next step involved a detailed analysis of the bargaining items that significantly differentiate among the four groups. Table 5.2 details the bargaining attainments for each of the four 'core' groups.

Looking at 'Pay For On-Call', we can see that the technicians had an early lead but the nurses regained the lead in 1978 and kept it, along

TABLE 5.1
BARGAINING RESULTS FOR "CORE" GROUPS CANAD 1970 1985

PAY FOR ON-CALL	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES		19	19	19	19	25	25	25	44	44	50	56	1.25	1.25	1.25	1.25
TECHNICIANS				25	25	31	31	31	19	19	23	25	1	1.25	1.25	1.25
PHARMACISTS								31	44	44	44	44	1	1.25	1.25	1.25
THERAPISTS				19	19	25	25	25	44	44	44	44	1	1.25	1.25	1.25

MILEAGE	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES		6.25	6.25	8.13	8.75	8.75	9.38	9.38	12.5	12.5	15.6	15.6	23	28	28	28
TECHNICIANS				8.75	8.75	9.38	9.38	12.5	12.5	12.5	16	18	23	28	28	28
PHARMACISTS								11.25	12.5	12.5	16	16	23	28	28	28
THERAPISTS				6.25	6.25	9.38	9.38	11.25	12.5	12.5	16	16	23	28	28	28

NOTICE OF LAYOFF	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES							5	5	10	10	10	10	10	10	10	10
TECHNICIANS				5	5	5	5	5	5	5	5	5	5	5	10	10
PHARMACISTS									5	5	5	5	5	5	10	10
THERAPISTS									5	5	5	5	5	5	10	10

RELIEF DUTIES	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES		.2	.2	.2	.2	.2	.2	1	1	1	1	1	1	1	1	1
TECHNICIANS				.2	.2	.2	.25	.33	1	1	1	1	1	1	1	1
PHARMACISTS										1	1	1	1	1	1	1
THERAPISTS				.2	.2	.2	.2	.25	.25	1	1	1	1	1	1	1

PAID VACATION	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES		1	1	1	1	1	1	1	1	1	1.27	1.27	1.63	1.63	1.67	1.67
TECHNICIANS				.8	.8	.8	.8	.8	1.07	1.28	1.28	1.28	1.33	1.33	1.67	1.67
PHARMACISTS								1	1.25	1.28	1.28	1.28	1.33	1.33	1.67	1.67
THERAPISTS		1	1	1	1	1	1	1	1.25	1.28	1.28	1.28	1.33	1.33	1.67	1.67

SHIFT DIFFERENTIAL	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES						16	16	16	20	22	30	35	75	100	100	100
TECHNICIANS							16	16	20	22	30	45	75	100	100	100
PHARMACISTS								16	16	22	30	35	75	100	100	100
THERAPISTS						16	16	16	16	22	30	35	75	100	100	100

SALARIES	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
NURSES		3.35	3.52	3.78	4.23	5.7	6.13	6.64	7.02	7.64	9.18	10.33	12.58	13.67	13.67	14.12
TECHNICIANS				3.32	3.47	5.1	5.51	5.84	6.34	6.88	7.46	8.04	11.52	12.12	12.55	13
PHARMACISTS								7.33	7.83	8.47	10.09	11.15	13.21	13.9	14.39	14.92
THERAPISTS		3.37	3.49	3.83	4.18	5.85	6.3	6.66	7.09	7.56	9.3	10.28	12.04	12.67	13.12	13.51

YEAR TO YEAR PERCENTAGE CHANGE IN SALARIES

NURSES			5.1	7.4	11.9	34.8	7.5	8.3	5.7	8.8	20.2	12.5	21.8	8.7	0.0	3.3
TECHNICIANS			NA	NA	4.5	47.0	8.0	6.0	8.6	8.5	8.4	7.8	43.3	5.2	3.5	3.6
PHARMACISTS			NA	NA	NA	NA	NA	NA	6.8	8.2	19.1	10.5	18.5	5.2	3.5	3.7
THERAPISTS			3.7	9.7	9.1	40.0	7.7	5.7	6.5	6.6	23.0	10.5	17.1	5.2	3.6	3.0

with the therapists and pharmacists. For 'Mileage', the technicians lead with all groups achieving equal levels by 1982. With regard to 'Notice Of Layoff', nurses lead the increase to 10 working days and parity was not achieved among all groups until 1984. For 'Relief Duties', the nurses again lead the way but parity was achieved much earlier, in 1979. 'Paid Vacation' shows nurses leading again except in 1978-81, with the other groups not catching up until 1984. And for 'Shift Differential', nurses lead in every year except 1981 (when technicians lead), the other three groups achieving parity in 1979.

5.5 Salaries As Key Indication

Only for 'Salaries' is there significant variance among the four groups. For most other bargaining items, the nurses lead the way so that the other three groups did not achieve parity in all areas until 1984. This strongly suggests that the nurses were the 'pattern setters' among the four groups, supporting our first hypothesis. This is confirmed by the fact that, during the therapists' 1977-78 negotiations, they were trying to stall their own negotiations until they could determine the nature of the nurses' settlement. As well, John Pedden of the Alberta Hospitals Association, Kay Willekes of the Health Sciences Association of Alberta and Dave Thomson of the United Nurses of Alberta all stated in interviews that the nurses set the pattern in hospital bargaining. The other groups wait for the nurses to first settle so they can use nurses bargaining attainments as targets. In fact all three of the 'core groups' now commence bargaining at least one month following the nurses.

By calculating the ratio of therapists salaries to the salaries of each of the other three members of the core group (see Table 5.3 and Graph 5.0), we can see that the salary relationship between the nurses and the therapists is quite stable, as it is with pharmacists. Of course, since the pharmacists and therapists are part of the same bargaining unit after 1979, we would expect their relationship to be quite stable.

Focusing on the therapist/nurse relationship, we can see that there is a slight shifting of relative salaries between the groups, until 1981 when the therapists started doing relatively less well than the nurses (a downward movement of the therapist/nurse line shows that therapists are receiving lower gains than nurses). But over all, the pattern of improving salaries for nurses is followed by an improvement in therapists salaries, which keeps the ratio close to 1.0, thus giving support for the conclusion that nurses are the pattern setters. The fact that 1979 is flat for all groups suggests that the change in bargaining status of therapists did nothing.

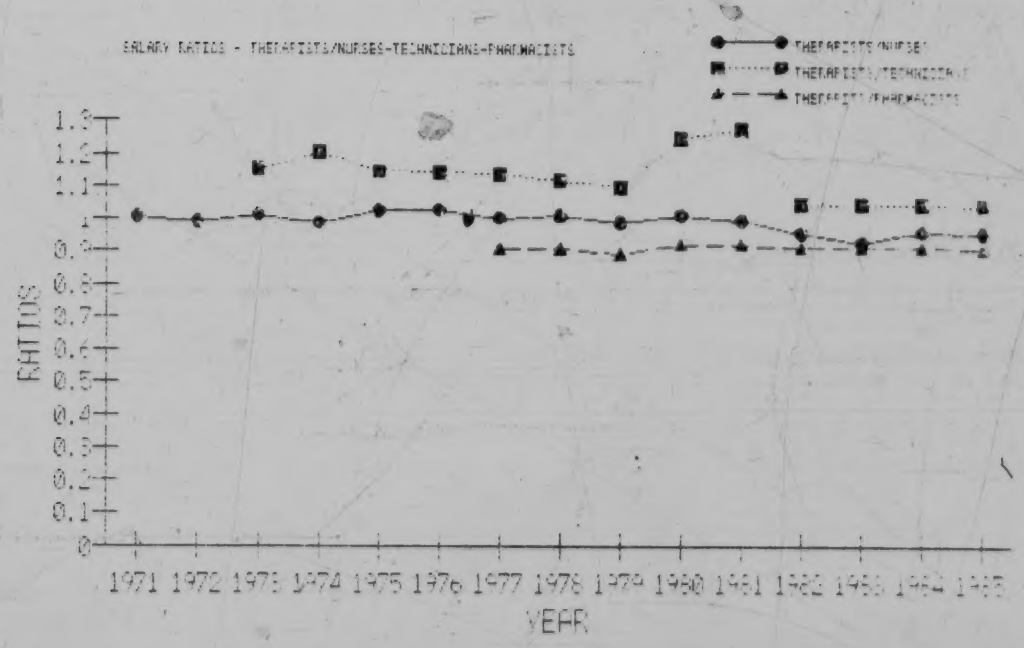
In terms of the relationship between technicians and therapists, the therapists moved considerably ahead in 1980 and 1981, but techniciansrecovered strongly between 1982 and 1985, supporting our earlier statement that the influence of the therapists' change in bargaining status may have become diluted.

TABLE 5.3

SALARY RATIOS

THERAPISTS/												
NURSES	1.01	0.99	1.01	0.99	1.03	1.03	1.00	1.01	0.99	1.01	1.00	0.9e
TECHNICIANS	NA	NA	1.15	1.20	1.15	1.14	1.14	1.12	1.10	1.25	1.28	1.05
PHARMACISTS	NA	NA	NA	NA	NA	NA	0.91	0.91	0.89	0.92	0.92	0.91

GRAPH 5.0



5.6 Conclusions

Based on the discussion in 5.4 above, we conclude that the nurses set the pattern for bargaining attainments among the members of the core group, in terms of most of the seven bargaining items measured, with the possible exception of salaries. Thus, there is support for our first hypothesis.

In this chapter we have looked at the attainments of our core group with respect to seven key bargaining items, determined that salaries are the item which most clearly differentiates the bargaining results among the four members of the core group and concluded that nurses do set the pattern for therapists bargaining. In the next section we will be looking at a variety of factors, other than pattern setting, that may also influence bargaining results, to test our second hypothesis.

Chapter Six

Factors Influencing Bargaining Outcomes On Salaries

6.1 Introduction

As stated in Chapter Five, Hypothesis 2 proposes that the significant increases in therapists' salaries in 1975 and 1980 were primarily the result of the change in the therapists' bargaining status from consultative association to fledgling trade union (1975) and from fledgling trade union to fully fledged trade union in 1980. To test the second hypothesis, we will review economic, situational and organizational factors that could affect therapists salaries and we also try to determine whether the therapists' salary increases, that were not explained by these other factors, are attributable to their change in bargaining status.

6.2 Economic Factors

6.2.1 Package Comparators

Laboratory technicians in Alberta received an increase in 1970 that raised their salary above that of nurses for the first time. This reversed the historical relationship where the nurses were always paid more than laboratory technicians. Nurses recovered their salary position above technicians in 1971 and maintain that lead today, but the events of 1970 started a practice of focusing on relative salaries among hospital industry employee groups which continues to the present time. As well, current negotiations regularly involve comparisons among groups both within the province and with similar groups in other

provinces. Our key concern is with the core groups, but because we wish to identify the influence of some broad economic factors, we have tabulated the salaries of our core and comparator groups in an attempt to identify salary trends that may help explain the salary movements of therapists during the study period.

Salaries of Therapists, Technicians and Nurses

Tables 6.1 through 6.3 show the year to year percentage change in weekly salaries of nurses, laboratory technicians and physiotherapists (See Appendix C for the actual salary data) in all 10 provinces for the 1970-1985 period (data for pharmacists was unavailable). The data show that major salary increases were recorded in most provinces from 1974-1975 and 1979-1980.

Table 6.1 shows that nurses in Newfoundland, Ontario, Manitoba, Alberta and British Columbia all received salary increases of around 30% in or around 1975. B.C. showed the smallest gains of the top five but they received back to back increases of more than 20% in both 1974 and 1975. Gains were generally modest during the 1977-1979 period but they again rose sharply for many groups during the 1980-1982 period. Still, the gains in the 1980-1982 period were considerably below those achieved around 1975.

Laboratory technicians exhibited salary gains quite similar to those noted for nurses. The change in definition of laboratory technician contributed in part to the large increases as their jobs were

TABLE 6.1
PERCENTAGE SALARY CHANGE-NURSES-CANADA & PROVINCES 1970-1985

YEAR	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA **	BC	CANADA
1969											
1970	7.6	13.6	8.5	2.8	20.0	8.3	10.6	8.8	8.5 *	8.4	11.3
1971	10.9	4.3	10.4	14.4	6.3	8.5	6.8	6.5	7.1 *	7.7	7.8
1972	6.8	6.2	5.5	8.7	6.0	7.1	5.9	4.6	5.1	7.8	6.1
1973	6.6	7.6	8.2	7.2	14.8	7.9	4.9	6.6	7.4	6.1	9.7
1974	28.5	NA	15.2	8.8	1.8	30.1	11.3	19.2	11.9	24.0	17.0
1975	8.9	NA	24.0	7.5	9.6	22.2	35.7	14.9	34.8	21.2	18.8
1976	27.9	NA	11.1	7.5	42.3	7.3	10.5	8.5	7.5	5.7	17.6
1977	0.9	NA	3.9	29.0	6.9	3.6	4.6	12.9	8.3	9.4	7.5
1978	5.9	NA	6.3	5.4	6.1	5.9	6.1	12.2	5.7	3.9	6.5
1979	3.8	NA	5.1	7.9	2.4	9.8	7.9	9.8	8.8	3.8	6.1
1980	19.7	NA	11.6	5.1	29.2	9.3	8.9	1.7	20.2	24.1	16.3
1981	1.7	NA	23.2	31.0	13.6	8.7	22.8	35.8	12.5	12.0	13.9
1982	42.8	NA	18.8	9.8	14.7	18.1	18.3	22.1	21.8	5.7	15.1
1983	9.7	NA	9.9	9.5	-2.8	11.9	6.1	12.0	8.7	4.1	5.4
1984	0.2	NA	3.3	5.7	3.0	2.9	3.7	-12.1	0.0	3.4	2.7
1985	0.4	NA	-1.4	4.4	2.4	5.4	2.3	2.6	3.3	2.1	3.8

NOTE: 1. ENTRIES REPRESENT CHANGE OVER THE PREVIOUS YEAR
2. NA = DATA NOT AVAILABLE
3. SOURCES - QUESTIONNAIRES SENT TO VARIOUS HEALTH ASSOCIATIONS ACROSS CANADA
- 'WAGE RATES, SALARIES AND HOURS OF LABOUR' , LABOUR CANADA
4. ** - DATA EXTRACTED FROM COLLECTIVE AGREEMENTS (FOR ALBERTA ONLY) EXCEPT WHERE DENOTED BY A *

TABLE 6.2
PERCENTAGE SALARY CHANGE-TECHNICIANS-CANADA & PROVINCES 1970-1985

YEAR	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA **	BC	CANADA
1969											
1970	8.1	NA	2.9	10.0	19.0	8.6	9.4	12.4	18.0 *	18.1	11.9
1971	2.8	NA	12.1	10.0	7.6	8.2	7.8	1.7	6.0 *	2.0	7.4
1972	1.8	NA	8.3	0.8	3.1	8.3	12.0	5.8	2.3 *	7.2	4.2
1973 ***	4.0	NA	4.0	4.0	4.0	4.0	4.0	4.0	4.0 *	4.0	4.0
1974 ***	4.5	NA	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5
1975	17.4	NA	4.2	NA	-2.1	25.6	33.3	66.9	47.0	7.2	19.1
1976	36.2	NA	6.8	NA	40.7	2.0	22.1	14.4	8.0	9.4	23.7
1977	1.6	NA	2.5	NA	26.8	15.5	-21.3	-2.0	6.0	4.3	10.0
1978	1.1	NA	6.2	NA	2.1	3.9	6.1	5.2	8.6	4.1	5.0
1979	1.6	NA	14.0	NA	2.9	5.0	15.4	6.9	8.5	8.3	14.2
1980	26.0	NA	8.2	NA	6.8	5.6	-0.8	-3.2	8.4	16.6	15.2
1981	4.9	NA	19.4	NA	13.5	8.3	15.5	35.1	7.8	7.6	16.8
1982	23.9	NA	17.9	NA	10.2	22.9	11.6	18.0	45.3	9.7	12.7
1983	16.5	NA	41.1	NA	6.9	4.8	3.6	10.6	5.2	8.5	7.3
1984	1.3	NA	0.0	NA	34.2	3.0	10.4	8.6	3.5	3.3	0.5
1985	5.0	NA	10.0	NA	-1.3	3.4	4.6	0.0	3.6	1.6	6.3

NOTE: 1. ENTRIES REPRESENT THE PERCENTAGE CHANGE OVER THE PREVIOUS YEAR
2. NA = DATA NOT AVAILABLE
3. SOURCES - QUESTIONNAIRES SENT TO VARIOUS ASSOCIATIONS ACROSS CANADA
- 'WAGE RATES, SALARIES AND HOURS OF LABOUR' , LABOUR CANADA
4. ** - DATA EXTRACTED FROM COLLECTIVE AGREEMENTS (FOR ALBERTA ONLY) EXCEPT WHERE DENOTED BY A *
5. *** - DUE TO ERRORS IN DATA, A 4% CHANGE IN WAGES WAS USED FOR ALL PROVINCES IN 1973 AND 4.5% IN 1974 (BASED ON THE ACTUAL EXPERIENCE IN ALBERTA)

TABLE 6.3
PERCENTAGE SALARY CHANGE-THERAPISTS-CANADA & PROVINCES
1972-1985

YEAR	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA **	BC	CANADA
1969											
1970											
1971											
1972	NA	NA	NA	7.9	NA	NA	6.7	NA	3.7	NA	NA
1973	NA	NA	NA	6.8	NA	NA	5.7	NA	9.7	NA	NA
1974	NA	NA	11.0	-1.6	13.4	23.1	8.3	NA	9.1	17.2	12.9
1975	NA	NA	20.9	-3.2	3.4	13.8	14.8	NA	40.0	26.8	21.9
1976	NA	NA	10.9	11.7	33.8	13.7	12.9	NA	7.7	15.8	13.9
1977	20.2	NA	2.5	15.4	12.5	4.5	13.6	NA	5.7	-2.4	9.3
1978	6.0	NA	3.2	14.2	10.8	5.9	6.0	NA	6.5	4.0	7.2
1979	4.2	NA	16.7	12.8	5.1	3.7	9.9	NA	6.6	7.5	2.4
1980	20.3	NA	12.3	9.0	20.7	11.1	7.4	0.0	23.0	10.9	13.7
1981	6.0	NA	13.0	19.0	7.2	9.7	19.4	NA	10.5	12.3	12.3
1982	33.8	NA	19.4	-1.3	13.7	21.4	15.2	NA	17.1	2.7	15.0
1983	8.1	NA	6.6	25.8	1.1	6.9	2.0	NA	5.2	8.7	4.1
1984	6.7	NA	0.4	5.6	4.8	3.0	9.6	12.2	3.6	4.6	4.3
1985	-3.9	NA	7.2	-1.4	1.0	4.2	2.3	0.3	3.6	2.1	2.4

NOTE: 1. ENTRIES REPRESENT THE PERCENTAGE CHANGE OVER THE PREVIOUS YEAR
2. NA = DATA NOT AVAILABLE
3. SOURCES - QUESTIONNAIRES SENT TO VARIOUS ASSOCIATIONS ACROSS CANADA
- 'WAGE RATES, SALARIES AND HOURS OF LABOUR' , LABOUR CANADA
4. ** - DATA EXTRACTED FROM COLLECTIVE AGREEMENTS (FOR ALBERTA ONLY)

reclassified to a higher level, but the pattern of settlements is the same --- major increases during the 1974-1976 period as well as the 1980-82 period, with increases in the former period being the larger of the two.

Data on therapists salaries across Canada was less available than that for nurses and technicians. Table 6.3 shows that 1975 was a year of major salary increases for therapists in some provinces but it is significant that no other therapist group received salary gains as large as those recorded by Alberta therapists. In the 1980-82 period, most therapists across Canada received similar increases.

Given the variety in settlements and the lack of data in some areas, it is difficult to draw specific conclusions regarding our core groups. We believe that the data does clearly suggest that the sharp increases in salaries for our core groups was, in large part, a reflection of the influence of very broad forces that affected workers in all industries.

Before we try to look further into these broadly based influences on salaries, it is useful to look at an example of salary attainments in Alberta outside the health sector. Table 6.4 shows salaries for engineers, electricians in maintenance and construction and librarians in Alberta during the 1975 - 1984 period. 1975 was generally a year of sharp increase for these groups, as was the 1980-1982 period, but unlike the situation in the health sectors, the difference between the

TABLE 6.4
PERCENTAGE CHANGE IN SALARIES–SELECTED GROUPS
ALBERTA 1975–1985

YEAR	1: JUNIOR ENGINEER	2: ELECTRICIAN MAINTENANCE	3: ELECTRICIAN CONSTRUCTION	4: LIBRARIAN at U of A	5: AVERAGE WEEKLY EARNINGS - ALL GROUPS -
1975	20.1	16.2	3.2	7.5	16
1976	7.6	7.8	26.7	14.6	14.2
1977	9.5	9.6	10.2	9.3	10.6
1978	9.6	6.5	8.3	6.2	9.7
1979	7.8	10.8	6	5.1	10.7
1980	16.8	11.2	9.3	2.5	12.6
1981	16.3	8.6	6.9	7.9	14.4
1982	16.8	10.9	9.8	20.2	11.9
1983	3.4	10.5	16.3	16	-.4
1984	3.7	2.3	0	9	1.1

NOTE: 1. SOURCES - APEGGA pages 23-24
- U of A SALARY SCALES - LIBRARIANS
- STATISTICS CANADA

magnitude of increases received by these groups in 1975 versus 1980-1982 was relatively small. As well, we see that average weekly earnings increased by similar amounts in 1975 and 1980-1982.

As a result, it seems reasonable to draw two general conclusions from this information. First, the health industry underwent a major correction in salaries in 1975 that was spread across health occupations throughout Canada. Other industries showed significant increases at the same time but they were not as large as those found in the health industry. This supports the proposition that this was a time of correction or catch-up for health industry workers rather than a time of large salary increases for all workers. Second, the salary increases realized by the health industry in the 1980-82 period, which were much more in line with the increases realized in other industries, were most likely the result of a general economic movement that affected all industries in a similar fashion. This suggests that their bargaining status may still have been a factor in 1975, but it looks like other factors account for much of the increases found in 1980.

The next section addresses some of the more broadly based influences as well as one very specific influence, the guidelines established by the Anti Inflation Board.

6.2.2 Price Impacts

When trying to understand the salary movements of therapists and other

health industry employee groups over the 1970-1985 period, a review of the effects of the Anti-Inflation Board (AIB) guidelines is essential. In the following sections we look at the impact of the AIB on the salaries of health industry workers, particularly around 1975 when the members of our core groups all received considerable salary increases. An article by F. Reid (1982) provides a thorough background on the influence of AIB guidelines and the following discussion draws heavily from that work. While the AIB guidelines expired in 1978, we also try to draw some parallels from the circumstances surrounding the 1975 period to the 1980-81 period when we saw the second spike in the salary attainments of our core groups. Of course, our prime interest in these two periods relates to the change in therapists' bargaining status from a consultative association to a fledgling trade union in 1975, and from a fledgling trade union to a fully fledged trade union in 1980. (Note that although the therapists' bargaining status changed in 1979, 1980 was the first year during which therapists bargained under this new status.)

Reid indicates that the AIB guidelines had a significant impact on wage settlements in Canada, particularly in the health sector.

> On 13 October 1975 Prime Minister Pierre Trudeau shocked the nation by announcing a comprehensive three-year programme of wage and profit controls...For those involved in industrial relations in the health sector the programme was especially important...certain parts of the health sector suffered a particularly severe impact from the controls programme. In addition, large wage settlements in the health sector were one of the contributing factors leading to the government's decision to implement controls. The main reason the controls were introduced was the government's concern over the sharp rise in wage settlements and inflation in 1974 and 1975.(Reid: 1982, Pp.304-5).

The first two columns of Table 6.5 show substantial increases in the inflation (CPI) rate in 1974 and 1975 and again in 1980, 1981 and 1982. As Reid states,

> The government was, however, even more concerned with the rising level of wages in the economy. Maslove and Swimmer conclude from numerous interviews with those involved in the decision to implement controls that key government decision-makers, including those in the Prime Minister's office, recognized that the key problem was public sector wage increases (especially at the municipal level) and in the quasi-public sector (i.e. education, hospitals) These settlements were running considerably higher than those either in the private sector or the federal public sector. Thus the health sector was one of the prime targets of the controls programme. (Reid: 1982, p.306).

The data on collective bargaining settlements (See Table 6.5) for the health and welfare sectors in Ontario and the 'core groups' in Alberta are particularly interesting as they illustrate, when compared to 'all industries' in those two provinces and Canada, how much higher the settlements were in the health sector. Settlements for 'all industries', which were averaging 10% in 1973, rose sharply to an average of 15% in 1974 and 17% in 1975. But those were mild increases compared to the increases in the health industry. As the data on Alberta and Ontario in Tables 6.1 through 6.3 show, settlements of 30% to 40% were common in the 1974-1975 period.

It is clear that these large settlements were out of the ordinary but what was fueling these dramatic changes?

> On the one hand, the inflation rate had increased substantially but not enough to explain all of the increase in wage settlements. Labour market conditions appeared weak, as indicated by the unemployment rate which was high compared to the boom period of the 1960's. The high wage settlements which were observed during what appeared to be a recession generated rather a desperate feeling in

TABLE 6.5

RATES OF INCREASE IN THE : CPI, UNEMPLOYMENT RATE, BASE WAGE RATE AND AVERAGE WEEKLY EARNINGS
- SELECTED JURISDICTIONS -

YEAR	CPI:		UNEMPLOYMENT:		MAJOR C/B SETTLEMENTS: **				HEALTH SECTOR:					
										ALL GROUPS ONTARIO:				CORE GROUP
	ALTA.	CAN.	ALTA.	CAN.	ALTA.	B.C.	ONT.	CAN.		Q1	Q2	Q3	Q4	ALTA.
1967	3.9	3.7	3.7	3.8	8.8	8.1	7.8	8.3						
1968	4.5	4.1	3.3	4.5	8	7.7	8.4	7.9						
1969	4.1	4.5	3.4	4.4	8.8	8.3	8.2	7.7						
1970	3	3.3	5.1	5.7	8.2	9.5	9.1	8.5						10.1
1971	2.8	2.9	5.7	6.2	7.5	8.6	7.6	7.8				[11.0][11.8]		9.8
1972	4.6	4.7	5.6	6.2	8.1	9.1	7.9	8	[8.2][7.8][11.0][9.7]					4.9
1973	7.3	7.7	5.3	5.5	10.1	12	9.4	10.5	[8.1][10.3][9.0][10.6]					1.4
1974	11.2	10.9	3.5	5.3	15	18.1	13	14.6	[17.2][26.1][30.6][28.9]					18.2
1975	11.2	10.8	4.1	6.9	21	17.9	14.4	17.2	[29.6][28.7][14.2][---]					17.9
1976	8,1	7.5	4	7.1	9.7	8.2	9.8	10.2	[---][10.2][11.2][10.1]					9.2
1977	8.8	7.9	5.1	4.5	7.5	7	7.4	7.7	[7.4][6.7][7.2][7.2]					5.1
1978	8.7	8.8	4.7	6.2	7.2	6.7	6.4	6.9	[7.0][6.9][6.5][6.2]*					6.4
1979	9.8	9.2	3.9	7.4	7.9	9.3	7.1	8.2	[6.2][7.1][9.7][7.6]					14.3
1980	11.2	10.2	5.7	7.5	11.3	12.7	9.6	10	[10.2]					15.5
1981	12.9	12.5	5.8	7.5	12.7	13.5	11.5	12.3						11.9
1982	11.4	10.5	7.7	11				10						17.3
1983	5.1	5.8	10.9	11.9				5.6						10.7
1984	3.6	4.4	11.2	11.3				3.5						1.4
1985	3.1	4	10.1	10.5										3

NOTE: 1. SOURCES - STATISTICS CANADA
- LABOUR CANADA

2. C/B = COLLECTIVE BARGAINING

3. ** - INCLUDES ALL INDUSTRIES EXCEPT CONSTRUCTION

4. [Q1 - Q4] REPRESENT THE FOUR QUARTERS OF THE YEAR RESPECTIVELY

> government that previous economic relationships had broken down, 'things were out of control', and dramatic action was required.
>
> Subsequent research, however, has indicated that a substantial change in the relationship between the unemployment rate and labour market conditions occurred in the early 1970s, with the result that the government may have seriously misread the labour market conditions in 1974-75. Taking account of this change, the high wage settlements during this period become more readily understandable. (Reid: 1982, p.309).

In Alberta, unemployment was low compared to the rest of Canada but it dropped lower still in the 1979-1981 period, so we cannot attribute the dramatic rise in health industry salaries to high labour demand, at least not to this alone.

We cannot precisely determine the impact this changed labour market relationship had on salaries, but, since the change would affect all employees, it is clear that the dramatic increases in the Alberta health sector cannot be completely explained by a change in the relationship between the unemployment rate and labour market conditions. The similar dramatic increase in health sector salaries in Ontario, as shown in Table 6.5, suggests that there was a general move towards significantly higher salaries in that industry. Tables 6.1 through 6.3 show a general and widespread increase in salaries for nurses, technicians and therapists in the 1974 to 1976 period. In fact, we see a similar pattern in the 1980-81 period, where average settlements in the 8% range increased by 10% to 13%, while substantially larger increases were recorded for nurses, therapists and technicians in that same period. The hospital sector received such large increases in 1975, that the 'experience adjustment factor' (the

amount salaries were allowed to increase under AIB controls) caused their guidelines to be decreased in most cases by a full 2% per year during the three years the AIB guidelines were in effect. Table 6.6 shows that the salary attainments of our core group did not keep pace with inflation during the 1976-1978 period.

TABLE 6.6

AVERAGE YEAR TO YEAR INCREASES - 1976-1978

YEAR:	1976	1977	1978	3-year average
CPI	8.1	8.8	8.7	8.5
NURSES	7.5*	8.3*	5.7	7.2
TECHNICIANS	8.0	6.0	8.6	7.5
PHARMACISTS	—	—	6.8	6.8 **
THERAPISTS	7.7	5.7	6.5	6.6

Note: ** - figure based on the 1978 increase

[Also note: The data shows that some groups received increases above the AIB guidelines during the prices and wages control period. Detailed data from collective agreements was only available for Alberta so we cannot determine the reason for these exceptions. * Mr. Justice Bowen's award was deemed exempt from AIB guidelines].

Considering this experience we believe that the factors outlined above explain a major portion of the salary increases in and around 1979 as a 'catch-up' for losses due to inflation during 1976-1978.

An analysis of all the factors that could have influenced these

changes for all these groups in each jurisdiction is beyond the scope of this thesis but it does suggest there were many influences involved beyond the change in the bargaining status of Alberta therapists. Those persons interviewed for this thesis felt that inflation and the nurse's settlements are the key influences.

As a final point, the influence of 'inflationary expectations' likely made groups seek higher wages. They were not receiving wage increases equal to inflation and they were also expecting inflation to continue, leading them to expect their salaries to increase. We cannot determine precisely the impact of these 'expectations' on salary attainments but since inflation affected everyone we can suggest that the average settlements in all industries may be a reasonable proxy for these 'expectations'.

6.2.3 Ability To Pay

The concept of 'ability to pay' has long been an accepted part of private sector collective bargaining. Generally stated, the ability to pay of a private company is the amount that can be paid to labour while still allowing the company to make a profit. Because public sector institutions are not generally profit making, 'ability to pay' takes on a different character. (See section 3.2.3 for a more detailed discussion of how economic forces affect public and private sector institutions differently).

As Brewin and Kilcoyne (1983) suggest in reference to the establishment of public sector compensation rates, "Properly considered, 'ability to pay' is a matter for the political arena". ." Since the employer depends on funds generally provided by the citizenry in the form of taxes, distributed through the legislature of the jurisdiction in question, ability to pay is ultimately determined by the ability of the citizenry to bear his or her share of the tax burden. Appropriately then, the impact of 'ability to pay' on negotiated settlements would best be determined by relating salary increases to increases in the citizenry's ability to pay taxes. Unfortunately, because ability is such a vague concept, affected by numerous factors including willingness to pay and, particularly in the health area, desire or need for the service, we could not develop an appropriate measure. Instead, we have turned to the field of public sector interest arbitration in an attempt to measure how 'ability to pay' affects salary outcomes.

Brewin and Kilcoyne suggest that interest arbitrations generally arise under the provision of a statute.

> Occasionally parties agree to refer a wage question to an interest arbitrator — new job classification rates are an example. Most of the time, however, interest arbitrations are provided for in legislation designed to avert strikes or lock-outs in 'essential' services. This invariably means the public sector or that part of the private sector heavily regulated by public authorities (Brewin, Kilcoyne: 1983, p.6.Ø1).

Interest arbitrators are guided by two general structures, 'comparability' and 'legislation.'

> Almost invariably, the criterion of "comparability" is accorded a postion of pre-eminence by interest arbitrators and legislative drafters alike. Arbitrators have expressed their role as an attempt to replicate what the parties would have agreed to if they had been left to their own devices. (See Fernie District Teachers' Association and Board of School Trustees, School District No.1 Fernie), J.E.Dorsey Chairman, December 21, 1982). The most useful guideline therefore is a voluntary settlement in a comparable situation. Other subordinate factors often considered include changes in the cost of living, labour supply requirements (recruitment/retention) and productivity forecasts. (Brewin, Kilcoyne: 1983, p.6.Ø1).

We addressed 'comparability' ~~in~~ section 6.1 and found that voluntary settlements had a significant influence on the bargaining attainments of therapists, particularly when the comparator group was nurses. As well, the influence of other economic factors were reviewed. We also suggested, however, that 'involuntary settlements', which we consider, include settlements by interest arbitration as well as by strikes or lockouts, had considerable influence on salary outcomes. The affect of strikes on bargaining outcomes has been debated in many arenas with

the general conclusion that job actions, just like the general impact of unions, have had a positive influence on the bargaining outcomes of employee groups. It is also clear that interest arbitration affects salaries, as they set the salaries in many cases, but the role of 'ability to pay' in those arbitrations is less apparent.

Arguments regarding the use of 'ability to pay' in interest arbitration are presented both for and against. Owen Shime in Re: B.C. Railway Co.(June 1, 1976) is particularly articulate in his statements against using the 'ability to pay' criterion :

> With the introduction of collective bargaining into the public sector there has also been some attempt to import into public sector bargaining many of the concepts that historically have been a part of private sector bargaining without making all the necessary distinctions between the public sector and the private sector. In the private sector, consideration was often given to an employer's profit and loss statement and many early cases concerning bad faith bargaining dealt with a union's right to have access to the financial records of the companies. In the public sector, however, the employer, as the government, is required to provide services to the community it is elected to represent and these services cannot be evaluated on a balance sheet or profit and loss statement in the same manner as a private sector company. Indeed many services, to name a few - the distribution of pension and welfare cheques, the providing of hospital or firefighting services, the supervision of health and sanitation - can neither be considered nor assessed in the same manner as a private business. Also, there are many public sector activities that operate at a loss, but are considered necessary for the vital operation and well-being of the community. In the instant case, the operation of a railway is an example of an industry which is necessary to the community - to the servicing and opening of remote areas, but which traditionally has operated at a loss with the full knowledge and acquiescence of the community which considers the service as vital to its well-being.
>
> The operation of the industry at a loss does not justify employees receiving substandard wages. On balance, the total community which requires the service should shoulder the financial loss and not expect the employees of the industry to bear an unfair burden by accepting wages and working conditions which are substandard; that

is not to say that the public sector employer ought to be the best employer in the community - it need not. Rather, it should be a good employer and also be seen as a fair employer.

Related to this concept of a good and fair employer is the notion of ability to pay which has often been mooted as one of the criteria in public sector bargaining.

Once it is accepted that the public sector employer does not operate with a view to a profit and once accepted that it may also operate at a loss, it becomes clear that it may not have the necessary resources required to pay the employees. It must gain this financial support through the taxing power whether directly or indirectly. In almost all cases the financial means are available through taxation, and more to the point, quite often the differences between the union and the employer are such that if taxes were increased the financial burden could be readily borne by each member of the community bearing his or her proportionate share of the cost. Thus, each member of the community should bear his or her share of the required public service without the necessity of the employees bearing the unfair burden of substandard wages or working conditions.

This position should not be considered as suggesting that the source of funds from the community is inexhaustible or that there are not political realities to be considered prior to the taxing power being exercised. But, that does not detract from the reality that the public or quasi public sector employer is not subject to the same market place conditions or assumptions that affect the private sector employer.

In sum, I determine that on balance, if the community needs and demands the public service, then the members of the community must bear the necessary cost to provide fair and equitable wages and not expect the employees to subsidize the service by accepting substandard wages. If economies are required to cushion the taxes then they may have to be implemented by curtailing portions of the service rather than wages and working conditions. (Brewin, Kilcoyne: 1983, Pp.6.Ø2-6.Ø3).

These views have been endorsed and adopted in countless awards. (Brewin Kilcoyne: 1983, p.6.Ø3)

As well...

a leading American text, Elkouri and Elkouri, How Arbitration Works, takes the view that ability to pay is "a rather abstract if not an academic concept, of little use as a standard in adjudication". (Brewin Kilcoyne: 1983, p.6.Ø3).

Still others recognize...

> ...that ability to pay is a political issue involving value judgements: how much to extend existing deficits, which expenditures are priorities, can tax revenues be increased or at what level are public services to be provided. As one B.C. arbitrator noted: "...the combatting of inflation and the restructuring of public sector spending are matters that have to be resolved in the public domain. It would require express language in the Essential Services Dispute Act to impose that jurisdiction on the board." (Hospital Labour Relations Association v. Hospital Employees' Union, H.A.Hope, 1978). Dalton Larson, in H.L.R.A. v. Health Sciences Association (1978), made the same point: "...any question of what is in the public interest is a political decision requiring the measurement of consensus."

In the passage of Bill 44 (Labour Statutes Amendment Act, 1983, Chapter 34), the government of Alberta appears to have taken the point that 'ability to pay' requires express language, by requiring arbitrators to consider government fiscal policies and the current economic situation, when making their decisions. Labour's view of arbitration under these conditions is that Bill 44 denies basic trade union rights to hospital workers in Alberta (Werlin, 1984) but regardless of the equity of the process, arbitration influences salary attainments.

In sum, we can conclude that 'ability to pay' has likely influenced settlements in the health industry since the passage of Bill 44 and has likely played a considerable role in the lower level of salary increases realized by our core groups since 1983, but had little impact prior to 1983. Yet since the criteria established in Bill 44 affects hospital workers as a whole, and as such would not influence the relative settlements of the various employee groups unless 'the current economic situation' affected the individual groups

differently, or, as was the case with Alberta nurses, a group refusesto submit to interest arbitration. We are mainly interested in the 1979-80 period, which is prior to the introduction of Bill 44, but it does help explain how the salaries of our four key groups have drawn closer together in the latter years as the nurses' ability to achieve large settlements by striking has been impaired.

Table 6.7 shows that expenditures on health care did increase in 1976-1977 and 1981-1982 but this was most likely a result of increased salaries rather than a cause. Those expenditures also likely reflect 'ability to pay' but we have found no evidence that 'ability to pay' has ever been linked to anything other than total employee aggregates. While it is possible that an individual employer would consider raising the salaries of his or her therapists in an attempt to fill vacant therapy positions, he or she would represent a relatively small portion of the work force as compared to nurses and other hospital employees. The structure of the industry tends to prevent such action in all but isolated cases.

Overall then, we have not seen any evidence to suggest that 'ability to pay' was a significant factor in the sharp increases in therapists' wages during the 1975 and 1980 periods.

TABLE 6.7
OPERATING EXPENDITURES ON HEALTH CARE - ALBERTA 1973-1983
(DOLLARS PER ALBERTAN)

YEAR:	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80	1980-81	1981-82	1982-83
EXPENDITURE: **	173	230	266	282	330	360	390	430	500	630

NOTE: 1. SOURCE - 1982 BUDGET ADDRESS - ALBERTA DEPARTMENT OF TREASURY
2. ** - FIGURES ESTIMATE BAR CHART ILLUSTRATION

6.2.4 Labour Market Influences

Now that we have analyzed some of the macro influences on salaries we feel it is appropriate to review some of the more specific labour market forces that may be influencing salaries. Table 6.8 shows the number of practicing therapists and nurses in Alberta during the 1976 to 1984 period. Economic theories of supply and demand suggest that if demand increases either the supply of workers, or, perhaps after a time lag, the prices paid for their labour will increase. The data shows that for therapists, the supply of workers increased significantly in 1977, 1979 and 1982, while the largest salary increases were recorded in 1980 and 1982. The large salary increase for therapists in 1982 was accompanied by a large increase in practicing personnel (17.1% versus 20.8%, respectively), but the large salary increase in 1980 followed the large increase in practicing personnel in 1979. Table 6.9 shows that vacancy rates for Alberta therapists were high in 1979 (13.8%), which may explain in part the substantial increase in practicing therapists. Yet vacancies in the following year were only marginally lower. Vacancies did increase in 1981 but the corresponding increase in practicing therapists was only 10.9%. In 1982, while salaries increased by 17.1% vacancies dropped to 8.1%. The timing of settlements could be a factor as high vacancy rates recorded subsequent to a settlement would have little influence until the following year, but we could not obtain sufficient data to address that question.

Based on this data we cannot conclude that vacancies are major

TABLE 6.8

NUMBER OF PERSONS PRACTICING, PRACTICING TO POPULATION RATIOS , AND
YEAR TO YEAR PERCENTAGE CHANGE IN SALARIES
- THERAPISTS AND NURSES - ALBERTA 1976-1984 -

THERAPISTS

YEAR	NUMBER PRACTICING	PRACTICING TO POPULATION RATIO	% CHANGE IN PRACTICING PERSONNEL	CHANGE IN SALARY LEVELS
1976	411	1 : 4472	----	7.7
1977	537	1 : 3546	30.7	5.7
1978	543	1 : 3615	1.1	6.5
1979	764	1 : 2652	40.7	6.6
1980	688	1 : 3103	-9.9	10
1981	762	1 : 2803	10.9	10.5
1982	921	1 : 2320	20.8	17.1
1983	984	1 : 2294	6.7	5.2
1984	864	1 : 2715	-12.2	3.6

REGISTERED NURSES

YEAR	NUMBER PRACTICING	PRACTICING TO POPULATION RATIO	% CHANGE IN PRACTICING PERSONNEL	CHANGE IN SALARY LEVELS
1976	14804	1 : 156	----	7.5
1977	15765	1 : 152	6.4	8.1
1978	17213	1 : 140	9.1	5.7
1979	18494	1 : 128	7.2	6.8
1980	19705	1 : 117	6.6	20.2
1981	16889	1 : 132	-7.8	12.5
1982	17767	1 : 131	5.1	21.3
1983	17770	1 : 133	0	8.7
1984	20124	1 : 117	13.2	3

NOTE : 1. SOURCES - SOCIAL SERVICE MANPOWER IN ALBERTA ALBERTA SOCIAL SERVICES AND COMMUNITY HEALTH
- TABLE 5.C (CHANGE IN SALARY LEVELS)

TABLE 6.9
VACANCY RATES-THERAPISTS AND NURSES-ALBERTA 1979-1985

YEAR:	1979	1980	1981	1982	1983	1984	1985
THERAPISTS	12.8	16.8	12.5	8.1	6.3	8.4	8.9
NURSES	3.7	5.3	6.6	2.6	3.2	2.1	3.3

NOTE: 1. SOURCE - SOCIAL SERVICE MANPOWER IN ALBERTA , ALBERTA SOCIAL SERVICES AND COMMUNITY HEALTH

influences on the variance in salary attainments for therapists as the therapist vacancy rate generally was high throughout the period. Discussions with therapist associations and the Alberta Hospitals Association indicate that therapists have been in short supply since the mid 1970's, a condition which persists today. The average vacancy rate for health and social service personnel in Alberta was considerably lower and more stable than for therapists.

The largest salary gains of nurses since 1978 occurred in 1980 and 1982 but increases in practicing nurses stayed in the 6% to 8% range until 1982. In 1982, when salaries increased by 21.8%, the increase in practicing personnel was only 5.2%. In the following year there was a zero increase in practicing nurses but vacancy rates increased, showing more demand.

As a result, there is little correlation between salaries and the supply of and demand for nurses and therapists. There does now appear to be a correlation between vacancy rate, lagged one year, and salary increases for both therapists and nurses, but we would require more data on vacancies to draw a strong conclusion. Yet, if vacancy rates were a significant influence on salaries, we would expect to see therapists salaries gaining relative to salaries of nurses, but this is not happening. The next section discusses occupational wage differences as one of these 'other factors.'

6.2.5 Occupational Differences

Reynolds (Labour Economics and Labour Relations) suggests that one-quarter of the total variation in earnings can be attributed to differences in average earnings of different occupations, while three-quarters of the differences are due to intraoccupational differences.

> There are many possible reasons for this surprising result...differences in the amount of time worked...hourly rates of pay...geographic differences...disequilibrium in the supply of labour and capital...differences in 'human capital' (personal characteristics) and education and training. (Reynolds: 1978, Pp.259-262).

While these factors may explain some of the differences we have seen between, for example, therapists in different provinces or between nurses and electricians, these factors tend to have little influence on the rate of increase within an occupational group like therapists.

We have used hourly rates instead of annual earnings to remove the influence of amount of time worked and we have seen that the impact of labour supply has not been clearly identified. By focusing on particularly qualified groups (i.e. therapists with degree) we have removed education and training as a factor, and, given that we are using salaries based on a broad union scale, there is little opportunity for differences in human capital to affect our results.

Overall, we can conclude that neither intra - occupational or inter - occupational wage differences seem to substantially explain the year to year variation in the salaries of therapists. The next section considers the possible influence of sanctions (strikes, lockouts and

interest arbitration) on the salary attainments of therapists and other health occupations.

6.2.6 Sanction Impacts

From Table 6.10 we see that there have been numerous work stoppages in the health industry since 1975. Nurses went on strike in 1977, 1980, 1982 and 1985. Service employees struck in 1975 and numerous support worker groups (locals of the Canadian Union of Public Employees [C.U.P.E.]) struck in 1978. Over time, the strikes generally lasted longer and involved more workers, but the nurses continued to account for the bulk of the strike activity. Therapists, pharmacists and technicians have yet to go on strike in Alberta, but, considering that we have suggested that nurses play a key role in setting settlement patterns within the 'core group', we should look at how the nurses' strike dates coincide with major salary increases.

In 1977 the nurses struck for 5 days and they received a salary increase approximating 8%. An apparently small gain, but as we noted in chapter four, it took a strike to get the employer to pay above the AIB guideline of 6%. In 1980, the nurses struck 79 units of the Alberta Hospitals Association for 6 days and received a 20% salary increase at arbitration. And in 1982, the nurses struck for 26 days, receiving an increase of approximately 22% plus a cost of living adjustment for 1983.

This does not shed any light on the nurses' increases in 1975, but the

TABLE 6.10

LEGAL STRIKES / LOCKOUTS OF NURSING PERSONNEL - ALBERTA 1975-1985

YEAR	UNION AND LOCATION	DATE: INITIATED	TERMINATED	NUMBER INVOLVED	WORKING DAYS LOST	PERSON DAYS LOST
1975	NONE REPORTED					
1976	NONE REPORTED					
1977	AARN - CALGARY	77.07.04	77.07.09	150	5	750
	AARN - CALGARY	77.07.04	77.07.09	650	5	3250
	AARN - EDMONTON	77.07.04	77.07.09	789	5	3945
	AARN - EDMONTON	77.07.04	77.07.09	861	5	4305
	AARN - GRANDE PRAIRIE	77.07.04	77.07.09	87	5	435
	AARN - LETHBRIDGE	77.07.04	77.07.09	42	5	210
	AARN - RED DEER	77.07.04	77.07.09	191	5	955
1978	CUPE # 838 - RED DEER	78.11.04	78.12.04	211	19	4009
	CUPE # 839 - INNISFAIL	78.11.13	78.12.04	24	14	336
	CUPE # 1159 - EDMONTON	78.11.13	78.12.04	397	14	5558
	CUPE # 1399 - FT. McMURRAY	78.11.13	78.12.04	35	14	490
	CUPE # 9 - CALGARY	78.11.20	78.12.04	1298	10	12980
	CUPE # 934 - CALGARY	78.11.20	78.12.04	75	10	750
	CUPE # 1240 - CALGARY	78.11.20	78.12.04	692	10	6920
	CUPE # 1352 - CALGARY	78.11.20	78.12.04	92	10	920
	CUPE # 1368 - EDMONTON	78.11.20	78.12.04	19	10	190
	CUPE # 189 - MEDICINE HAT	78.11.27	78.12.04	217	5	1085
	CUPE # 1868 - EDMONTON	78.11.28	78.12.07	72	4	288
1979	NONE REPORTED					
1980	UNA - 79 UNITS - PROVINCE WIDE	80.04.18	80.04.28	6000	8	48000
	UNA # 119 - CANMORE	80.04.19	80.05.22	14	22	308
	UNA # 117 - EDMONTON	80.09.27	80.10.10	8	9	72
	UNA # 48 - EDMONTON	80.10.17	********	16	51	816
1981	UNA # 48 - EDMONTON	********	81.12.31 **	16	291	4656
1982	UNA - 74 UNITS - PROVINCE WIDE	82.02.16	82.03.11	8230	17	139910
	UNA - 1 UNIT - ATHABASCA	82.05.03	82.05.31	21	19	399
	UNA - 4 UNITS - NORTH CENTRAL	82.05.03	82.05.31	99	19	1881
	UNA - 4 UNITS - SOUTH CENTRAL	82.05.03	82.05.31	101	19	1919
1983	NONE REPORTED					
1984	NONE REPORTED					
1985	UNA # 98 - EDSON	85.04.01	85.10.01	18	127	2286
	UNA # 89 - LETHBRIDGE	85.04.01	85.10.18	25	139	3475
	UNA # 97 - MEDICINE HAT	85.04.01	85.12.05	45	172	7740
	UNA - 5 UNITS - PROVINCE WIDE	85.04.01	86.01.27	121	189	22869
	UNA # 52 - CALGARY	85.04.22	------- ***	25	93	2325

NOTE: 1. SOURCE - PLANNING AND RESEARCH DIVISION OF ALBERTA LABOUR
2. ** - AS OF 81.12.31 THIS STRIKE WAS PLACED ON THE INACTIVE LISTING OF MEDIATION SERVICES
3. *** - STRIKE NOT OFFICIALLY TERMINATED. PERSON DAYS LOST WAS ACCUMULATED TO 85.08.31
- LOCAL NO LONGER UNDER CONTRACT WITH THE CITY OF CALGARY

analysis in earlier sections strongly suggests that earnings in 1975 were most likely the result of very broad economic forces plus a general increase in the health industry beyond that received in other industries. However, the significant increases in 1977, 1980, and 1982 appear to be the direct result of the strikes. If we accept the nurses as pattern setters for therapists (as well as pharmacists and technicians), the gains of the therapists in those years are also more easily explained. As a result of the AIB guidelines, the therapists could not expect to gain from the nurses example. In 1980, however, the nurses' strike likely had considerable influence on the 23% increase realized by the therapists. In 1982, the therapists again did well with a 17.1% increase, which was just behind the nurses settlement of 21.8%.

Considering the influence of the nurses as a pattern setter, we would expect to see other groups following their lead but not necessarily reaching quite as high a level. This happened in 1982, but in 1975, the settlement of the therapists exceeded the settlement of the nurses by 5.4% and in 1980, the therapists' salaries increased by 2.8% more than that of the nurses.

According to our analytical model, in 1980, the therapists bargaining power should reach its highest level. As well, it suggests that the differences between therapists' salaries and a 'free market rate' would be lowest, perhaps even exceeding that rate by virtue of the enhanced monopoly power achieved, by becoming a fully fledged union.

While it is difficult to calculate a 'free market' rate, we have attempted to approximate that rate by using, as a proxy, the salaries of pharmacists in the private sector. Table 6.11 compares the salaries of pharmacists in the private sector with those employed in hospitals.

TABLE 6.11

COMPARISON OF HOURLY SALARIES OF PHARMACISTS IN PRIVATE AND PUBLIC EMPLOYMENT ALBERTA 1980-1985

SECTOR	1981	1982	1983	1984	1985
Private	9.75	12.06	13.02	14.56	15.87 16.35
Public	10.09	11.15	13.21	13.90	14.39 14.92

Source: Alberta Pharmaceutical Association Survey of Retail Wages and Collective Agreements

Note: Retail pharmacist's wages are for employees with 1-2 years experience as hospital pharmacists are required to have either experience or a hospital residency program before entry level hiring.

While the data on the salaries of private sector pharmacists is limited, and there is some question of its reliability due to the small sample size non-random nature of its collection, it is interesting that public sector salaries exceed those of their private sector counterparts, from 1983 onward. This suggests that hospital pharmacists were being paid above 'free-market' rates in the 1980-82 period, but they fell behind as a result of the low level of year to year increases for the hospital pharmacists in the 1983-85 period.

In 1974 and 1979, nurses received increases of 11.9% and 8.8%, respectively, compared to therapists' increases of only 9.7% and 6.6%. As a result, it is quite possible that when therapists received larger increases in the years immediately following, that it was merely the result of efforts to maintain the traditional close relationship between the salaries of nurses and therapists, as shown previously in section 5.4. Yet in 1975, therapists did achieve a larger gain than nurses.

It seems reasonable, then, to conclude that bargaining status was not one of the key influences in raising the therapists salary attainments above those of the nurses,but it does not cause us to reject our earlier conclusion that the nurses play a key role as the pattern setters. As well, the findings regarding 'free-market' rates support our model's proposition that the wages of the members of a fully fledged union may exceed the 'free-market' rate.

6.3 Situational Influences

Fisher, et al. (1986) suggests that the situation within which a group bargains exerts considerable influence on bargaining outcomes. In this section we look at the 'situational factors' described by Fisher (see section 3.4) in an attempt to identify influences on therapist's bargaining outcomes beyond those economic influences discussed in the previous section.

6.3.1 The Nature of the Sector

Apart from those employed in private therapy clinics, therapists work in a public sector environment. As well, given that therapy services are covered under the Alberta Health Care Insurance program (a government medical insurance program), virtually all therapists' salaries are funded from government sources, either directly or indirectly. This has considerable impact on the therapists bargaining, not only because of the source of funding, but also because, apart from private therapy clinics, the government is the only employer.

Therapy is often a discretionary service, which also influences bargaining. While nurses have been able to impair the operation of hospitals within a relatively short time by withdrawing their services, (for example, during the first strike the nurses were legislated back to work after only 6 days) therapists interviewed during the 1977-78 negotiations suggested that it would be a much longer time before their services were missed.

Demographic data on therapists was not available but it is expected that they, like the nurses, can be characterized by a form of 'bi-modal' distribution. Participation is highest after graduation but drops steeply around age 30. Participation again increases around age 40 but never regains the levels following graduation. Many reasons are offered for this but the one most often cited is that many therapists, the bulk of whom are female, leave their employment to raise families and a relatively fewer number return to the profession as their families grow-up. This may not be a significant factor in

negotiations, but it likely has some effect on the extent to which the therapists press for improved salaries. Clearly if they are looking at a relatively short career they would be less concerned about the terms and conditions of their employment than if they were looking at a lifetime in the vocation.

6.3.2 History of Negotiations and the Negotiating Environment

The health industry experienced relatively quiet labour relations until the formation of the Staff Nurses Division of the Alberta Association of Registered Nurses (A.A.R.N.) in 1975. Prior to 1975, negotiations were handled in a 'consultative' fashion, with the employer taking the lead and consulting the employee associations when necessary. Early agreements were 'memorandums of understanding' and it was not until 1975 that we see more formal agreements. In 1975 the therapists' agreement doubled in length and in the number of clauses compared with the previous year's agreement.

In 1976, the nurses took another step with the formation of the United Nurses of Alberta, which was to be the group solely responsible for collective bargaining, and the A.A.R.N. would concentrate on the 'professional' issues of nursing. The therapists started to follow the nurses lead by forming a formal bargaining team for the 1975 negotiations but they did not achieve status as a fully fledged trade union until they joined the HSAA in 1979.

These changes in the negotiating environment do not explain away the

influence of inflation, comparability and other economic forces on salaries. It does seem reasonable to us that the unionization of the Alberta nurses in 1975 was a significant factor in pushing the salaries in the health industry above the already high levels experienced in all Alberta industries. John Pedden, Director of Labour Relation for the Alberta Hospital Association, commented that the strike in 1974 of provincial government employees and the formation of the Staff Nurse Division of the A.A.R.N. did encourage the employer to increase salaries of most hospital workers in 1975.

6.3.3 Legislation

Introduced in 1983, Bill 44 replaced the right to strike of hospital workers with binding interest arbitration. Prior to 1983, public emergency provisions in the Alberta Labour Act included mechanisms for returning striking employees to work if it was or was likely to harm the health or safety of the general public. Under those provisions, groups like the nurses could legally strike, even though they were almost certain to be ordered back to work at some point.

Under Bill 44, the legal right to initiate strike action was removed. Since 1983, we have seen the bargaining results of our four 'core' groups draw much closer together. By 1984, all four groups had exactly the same provisions with regard to the six bargaining items discussed in the previous chapter. Salaries, the seventh bargaining item, continued to vary but the difference was so slight as to be almost negligible. For example, in 1985, therapists received the lowest

increase at 3.0%, followed by nurses at 3.3% and technicians at 3.6%. Pharmacists had the highest increase of the four groups at 3.7%.

A major factor in these settlements was the poor economic performance of Alberta. As well, since the technicians, pharmacists and therapists have joined the HSAA, the terms of their collective agreements have drawn closer together. The effect of removing the nurses' right to strike, however, (only nurses have used the strike weapon) has contributed to the homogenization of the settlements. The nurses may still be the pattern-setters but without the strike weapon they are much less vigorous in that leadership.

6.4 Organizational Factors

Behind the increasing labour relations activity, was a trend to increasing technology in health care. With the increasing complexity of medical care, what was previously an occupation for realtively low trained personnel was requiring more and more training. Population growth in the post war period was placing increased pressure on staff and facilities alike. Increasing specialization and education were also changing the expectations of workers. All of these factors were affecting the organization's function within the hospital industry.

6.4.1 Bargaining Priorities

To this point we have only looked at the 'results' of bargaining, presuming that the differences in results are significant. This is a standard and, we believe, reasonable approach, but it does not

consider what thegroups were trying to accomplish. Clearly, the best measure of a group's achievements is the results obtained as compared to targets. If a group achieves its targets, it may not matter to that group whether its attainments are above or below the results of other groups. Unfortunately data on bargaining objectives was only available for our 'core groups' and only in 1978. A review of the attainments versus targets should still provide us with some insights into the performance of therapists.

Table 6.12 shows the bargaining priorities of nurses, technicians, pharmacists and therapists in 1978, as determined in interviews with members of bargaining committees of each of these groups during that year. Priorities were similar for most items. Therapists considered 'shift differential' to be a relatively low priority when compared to the other groups, but they gave 'notice of layoff' a higher priority. The rating of shift differential is explained by the fact that therapists do not generally work shifts. They received a notice of layoff clause for the first time in 1978 and it was likely to be an important item in that year.

TABLE 6.12

PRIORITY RANKING OF BARGAINING ITEMS: 1978

ITEM	NURSES	TECHNICIANS	PHARMACISTS	THERAPISTS
Wages	1	1	1	1
Pay for On-call	5	4	4	5
Mileage	6	6	6	7
Notice of layoff	7	7	7	3
Relief duties	4	5	5	4
Paid vacation	2	2	2	2
Shift Diffntl	3	3	3	6

Ranking Legend High=1 Low=7

Overall, we can find little variance among the priorities of the four groups. All placed salaries as the number one priority and only for the two items mentioned was there a difference among the groups of more than one position. Thus we can conclude that organizational bargaining priorities, in 1978, were not a significant influence on the 'vigor' with which a group pursued bargaining gains on a specific item.

6.5 Hypothesis 2

After analyzing the impact of the salaries, economic situation and organizational factors, we have found very little support for Hypothesis 2. Much of the increases in salaries for our core group was either the result of general economic activity or general increases within the health industry. Inflation was found to be a significant, positive influence on salaries, the AIB was seen as a negative

influence. Ability to pay seems to have played a large role since the passage of Bill 44, but that legislation was passed after the change in therapists bargaining status. The labour market is seen as having some impact, but there was no major variation noted in 1975 or 1980. Occupational differences did not explain year to year variances in the salaries of therapists, but the role of sanctions was significant, not directly for each group, but through the actions of the nurses who have been established as the pattern - setters. The nature of the health sector and the patterns of negotiations help explain some of the salary movements, but once the nurses started using the strike weapon they established themselves as the key factor in that listing. Finally, bargaining priorities were not found to be a significant influence. Overall, we have found little support for Hypothesis 2.

Based on the discussions and analysis provided to date, chapter seven provides our conclusions.

CHAPTER SEVEN

CONCLUSIONS

7.1 Introduction

The purpose of this thesis was to attempt to isolate the impact of bargaining status changes on the terms and conditions of employment for Alberta therapists. In the previous chapters we have analyzed the bargaining results of therapists, pharmacists, technicians and nurses in Alberta, as well as a variety of comparable groups both within and outside of Alberta. To determine the impact of changes in bargaining status we have prepared and tested two hypotheses:

1) The settlement patterns established by the nurses were the most significant influences on the bargaining results of therapists, and

2) Major increases in the bargaining gains of therapists in 1975 and 1980 were primarily the result of the changes in their bargaining status from a consultative association to fledgling trade union (1975) and from a fledgling trade union to a fully fledged trade union (1980).

Based on the work done in the previous six chapters of this thesis, we offer the following conclusions with respect to these hypotheses.

7.2 Hypothesis One

The collective bargaining settlements reached by Alberta nurses strongly influence the bargaining results of Alberta therapists for three key reasons:

1) As a large, relatively militant trade union, the nurses are the first group to the bargaining table. Their settlements set the target

for all other groups in the hospital industry and both the employers and the other employee groups use the nurse's settlements as a target.

2) The nurses strike actions in 1977, 1980 and 1982 were a key factor in the level of salary attainments reached by the nurses and the therapists.

3) The pattern of salary achievements for nurses demonstrates a continuing close relationship between nurses and therapists and suggests that therapists' salary attainments move in a manner designed to maintain that close relationship between the two groups.

Economic factors such as inflation and the general performance of the economy are significant 'base' influences in the salary attainments of nurses and therapists. These factors, however, influence the gains of all groups. It is the pull created by the actions of the nurses that moves therapists' salaries beyond this 'base.'

7.3 Hypothesis Two

The major increases in the bargaining attainments of therapists in 1975 and 1980 are the result of a number of factors, primarily:

1) the pattern-setting influence of the nurses, including their strike activities as well as the long term relationship between the two groups;

2) the forces of inflation and general economic activity;

3) the restraining effect of the Anti-Inflation Board guidelines and wage increases to catch-up with inflation after the AIB was discontinued;

4) the strong monopsony power of the employer, the Alberta Hospitals Association; and

5) the long term high vacancy rates for therapists;

Bargaining Structure More Important Than Bargaining Status

When conditions of excess demand exist, as they have with respect to the therapists, we would expect the salaries of that group to increase. That they have not increased significantly above those of comparable groups who have been in lessor demand is curious but is likely explained by the monopsony power of the employer and the strong leadership role played by Alberta nurses. The therapists did not achieve their bargaining priorities in 1978 and they have been unable to gain any significant, continuing advantage over their comparator groups, suggesting that the structure of bargaining, in particular the nurse-therapist relationship, is far more important than bargaining status.

Some Support For The Bi-lateral Monopoly Theory

The BMT predicts that as an employee group's monopoly power expands they will do relatively better vis-a-vis a monopsonist employer. In the case of Alberta therapists, while there have been slight improvements in their relative position, the employer has maintained an advantage by its ability to reduce the influence of both improved bargaining status and excess labour demand by keeping the nurse-therapist relationship as a key factor in salary attainments.

Analytical Model Unable to Account for the Influence of Bargaining Structure

As Rose (1984) noted, the transition from non-bargaining associations to unions has become quite common in the public sector. Our model suggests that as the bargaining status of therapists strengthened in the move from consultative association through fledgling trade-union and on to fully fledged union, the differential between 'free-market' rates and therapists' salaries will be reduced. While there is limited evidence that they did pull ahead of pharmacists employed in the private sector, for the propositions of the model to be supported we would need evidence that therapists salaries improved over those of similar groups who were not experiencing a change in their bargaining status. As a result, we cannot claim significant support for the model. Obviously, there were other factors influencing therapists' salaries that were not accounted for in the model, in particular the influence of bargaining structure. Thus when Joseph Rose poses the question "What effect had a change in status ...on... union effectiveness?" we can suggest that it may be minor unless there is little or no influence from bargaining structure (Rose: 1984, p.109).

In summary, we can therefore tentatively accept the first hypothesis and tentatively reject the second, concluding that the salary attainments of therapists in Alberta during the 1970 - 1985 period have been influenced most significantly by bargaining structure and the pattern setting efforts of Alberta nurses and others, rather than

attainments of therapists in Alberta during the 1970 - 1985 period have been influenced most significantly by bargaining structure and the pattern setting efforts of Alberta nurses and others, rather than the change in their bargaining.

7.4 Improvements To The Model

Considering the significant influence of bargaining structure on salaries, we would expect better results from a model such as ours if the bargaining groups could be somehow split. As well, we may see changes with the advent of interest arbitration as arbitration awards may serve to reduce the influence of bargaining structure. Interest arbitration is now in a stage of evolution so our work could serve as a 'stepping stone' to further study of what influences bargaining results.

7.5 Improving the Data

As noted in the report, there were many occasions where the lack of data prevented the pursuit of what might have been fruitful research directions. Better data on the salaries of private sector therapists and other para-medical professionals as well as for therapists in other provinces, would enable much more detailed analysis. Cross-sectional data is often available for recent years, but without better time series data it will continue to be difficult to identify and analyze meaningful trends. We believe that the para-medical professionals themselves would benefit most from such data and a closer liaison with interested researchers would be mutually beneficial.

Despite data gaps, it was possible to draw tentative conclusions about the major hypotheses and to demonstrate the impact of consumer price increases and bargaining structure, specifically the major functional group of nurses and the Alberta Hospitals Association, upon therapists' compensation packages. These impacts apparently swamped the impact of the change in the status of therapists, first as a consultative association, next as a fledgling trade union, and finally as a fully fledged trade union.

REFERENCES

Anderson, John and Morley Gunderson. Union-Management Relations In Canada. Don Mills, Ontario: Addison - Wesley (Canada) Limited, 1982.

Arthurs, H.W., D.D. Carter and H.J. Glasbeek. Labour Law and Industrial Relations in Canada. Second Edition. Toronto, Ontario: Butterworths, 1984.

Beal, E.F., E.D. Wickersham and P. Kienast. The Practice of Collective Bargaining. Fifth Edition. Homewood, Illinois: R.D. Irwin, 1986.

Brewin, John F. and John R. Kilcoyne. "Interest Arbitration - The Ability to Pay Argument," in Labour Arbitration - 1983. Seminar Co-ordinator: Dr.M.A. Hickling. Victoria, B.C.: The Continuing Legal Education Society of British Columbia, June 1983.

Carter, Allen M., Theory of Wages & Employment. Homewood, Illinois: R.D.Irwin, 1959

Fisher,E.G., Bourgeois,G., and Purdy,R., A Decision Framework of Labour Negotiations Under Uncertainty.Unpublished, 1986.

Fisher, E.G. and Stephen Kushner. Alberta's Construction Labour Relations During During The Recent Disasterous Economic Fluctuations. Relations Industrielles (forthcoming)

Hibberd,J.M. The Collective Bargaining Goals of Nurses in a Series of Labour Disputes. Edmonton, Alberta: Paper presented at The International Nursing Research Conference, May 1986.

Pen, J. A . General Theory of Bargaining. American Economic Review. March 1952, Volume 42, Pp. 24-42.

Ponak, Allen. Proceedings of the 1983 Labour Arbitration Conference / the University of Calgary. Calgary, Alberta: The University of Calgary, 1984.

Ponak, Allen. "Public-Sector Collective Bargaining," in Union-Management Relations In Canada. eds. John Anderson and Morley Gunderson. Don Mills, Ontario: Addison-Wesley (Canada) Limited, 1982.

Reid, F. "Effects of Incomes Policy on Health Industrial Relations In Canada," in Industrial Relations and Health Services. eds. Amarjit Singh and Stuart J.Dimmock. London, England: Croom Helm Ltd, 1982.

Reynolds, Lloyd G. Labour Economics and Labour Relations. Inglewood

Cliffs, N.J.: Prentice Hall, 1978.

Rose, Joseph B. "Growth Patterns of Public Sector Unions" in The Future of Public Sector Industrial Relations. eds. Mark Thompson and Gene Swimmer. Montreal, Quebec: The Institute for Research on Public Policy, 1984.

Weiler, Joseph M. Interest Arbitration, Measuring Justice in Employment. Toronto, Ontario: The Carswell Company Ltd., 1981.

Wetzel, Kurt and Daniel B. Gallagher. "Management Structures to Accommodate Multi-Employer Hospital Bargaining in Western Canada," in The Future of Public Sector Industrial Relations. eds. Mark Thompson and Gene Swimmer. Montreal, Quebec: The Institute For Research on Public Policy, 1984.

Werlin, David. "Labour's View of Arbitration," in Labour Arbitration, Conference Proceedings, June 4 and 5, 1983. eds. C.L. Rigg and Allen Ponak. Calgary, Alberta: The Faculties of Law, Management and Continuing Education at the University of Calgary, 1984.

Williams, C.B. "Negotiating the Union-Management Agreement," in Union-Management Relations in Canada. eds. John Anderson and Morley Gunderson. Don Mills, Ontario: Adison-Wesley, 1982.

Alberta Board of Industrial Relations, Bulletin # 3

Alberta Treasury, Annual Reports: 1969-1985

The Association of Professional Engineers, Geologists and Geophysicists of Alberta, (APEGGA). The Value of Professional Services, 1986

COLLECTIVE AGREEMENTS

BETWEEN:	AGREEMENTS ACQUIRED:
Alberta Hospital Association and The Association of Chartered Physio Therapists of Alberta and the Alberta Society of Occupational Therapists	Jan 1, 1971 - Mar 31, 1973 Apr 1, 1973 - Dec 31, 1974 Jan 1, 1975 - Dec 31, 1975 Jan 1, 1976 - Dec 31, 1976 Jan 1, 1977 - Dec 31, 1977
Alberta Hospital Association and The Association of Chartered Physio Therapists of Alberta and the Alberta Association of Registered Occupational Therapists	Jan 1, 1978 - Dec 31, 1978 Jan 1, 1979 - Dec 31, 1979
The Royal Alexandra Hospital and The Alberta Division Employee Pharmacists' Association	Jan 1, 1977 - Dec 31, 1977 Jan 1, 1978 - Dec 31, 1979
Alberta Hospital Association and The Health Sciences Association of Alberta	Apr 1, 1973 - Dec 31, 1974 Jan 1, 1975 - Dec 31, 1975 Jan 1, 1976 - Dec 31, 1976 Jan 1, 1977 - Dec 31, 1977 Jan 1, 1978 - Dec 31, 1979
Calgary General Hospital Board and The Health Sciences Association of Alberta (Paramedical Professional Division)	Jan 1, 1979 - Dec 31, 1979
Alberta Hospital Association	

and	Oct 20, 1980 - Dec 31, 1981
The Health Sciences Association of Alberta (Paramedical Professional Division)	Dec 1, 1980 - Dec 31, 1981 Jan 1, 1982 - Dec 31, 1983 Jan 1, 1984 - Dec 31, 1985
Alberta Hospital Association	
and	Dec 1, 1980 - Dec 31, 1981
The Health Sciences Association of Alberta (Paramedical Technical Unit)	Jan 1, 1982 - Dec 31, 1983 Jan 1, 1984 - Dec 31, 1985
The Misericordia Hospital	
and	Jan 1, 1971 - Mar 31, 1973
The Registered Staff Nurses' Association of Misericordia Hospital	Apr 1, 1973 - Dec 31, 1974
The Edmonton General Hospital	
and	Apr 1, 1973 - Dec 31, 1974
The Registered Nurses' Staff Association of Edmonton General Hospital	Jan 1, 1975 - Dec 31, 1975 Jan 1, 1976 - Dec 31, 1976
Hospital Boards	
and	Jan 1, 1977 - Dec 31, 1977
Staff Nurses' Division in Alberta	
Alberta Hospital Association	
and	Jan 1, 1978 - Dec 31, 1979
The Staff Nurse Committee of the Alberta Association of Registered Nurses	
Alberta Hospital Association	
and	Jan 1, 1978 - Dec 31, 1979
The United Nurses of Alberta	Jan 1, 1980 - Dec 31, 1981 Jan 1, 1982 - Dec 31, 1983 Jan 1, 1984 - Dec 31, 1985

List of Persons Interviewed

John Pedden - Director of Labour Relations,
Alberta Hospital Association. (May 1986)

Dave Thomson - United Nurses of Alberta. (May 1986)

Kay Willekes - Executive Director,
Health Sciences Association of Alberta.
(June 1986)

Yvonne Chapman - Alberta Association of Registered
Nurses. (July 1986)

APPENDIX A

HSAA represents:

Paramedical Professionals:

Physiotherapists
Psychologists
Laboratory Scientists
Audiologists
Prosthetists
Orthoptists
Pharmacists
Speech Pathologists
Dieticians
Occupational Therapists
Social Workers
Teachers of Hearing Impaired
Kinesiologists
Recreational Therapists
Psychology Assistants
Orthotists
Psychometrists
Teachers of Visually Impaired
Mental Health Therapists
(Glenrose Hospital)
Play Therapists
(Edmonton General Hospital)
Child Development Workers
(University Hospitals)
Home Economists
(Mental Health Hospitals)
Rehabilitation Practitioners
(Alberta Hospital Ponoka)
Work Assessment Officers
(Workers' Compensation Board)
Technical Instructors
(Workers' Compensation Board)
Nurse
(Workers' Compensation Board)

Paramedical Technicals:

Laboratory Technologists
Laboratory Assistants
Cardiology Technicians
Certified Combined Technicians
Pharmacy Technicians
Health Record Technicians
Psychology Technicians
Audio Visual Technicians
Dialysis Technicians
Dental Technicians
E.E.G. Technologists
Medical Radiation Technologists
(Diagnostic and Therapeutic)
Orthotic Technicians
Nuclear Medicine Technologists
Medical Library Technicians
Anaesthesia Technicians
Glaucoma Technicians
Remedial Gymnasts
E.M.G. Technicians
E.N.G. Technicians
Medical and Biological
Photographers
Medical Illustrators
Diagnostic Sonographers
Physiological Lab. Technologists
Respiratory Technologists
Health Records Administrators
Dietary Technicians
Neuropsychology Technicians
Ophthalmic Photographers
Perfusionists
Registered Emergency Paramedics
Emergency Medical Technicians
Prosthetic Technicians
Applicance Technicians
(Glenrose Hospital)
Clinic Assistants
(Red Cross)
Laboratory Clerk Typists
(Red Cross)
Stores Accountant
(Red Cross)

Darkroom Assistants
(Baker Clinic)

APPENDIX B

QUESTIONNAIRE FOR ACPA AND AAROT MEMBERS

(Please answer each question by placing an "X" in the appropriate box)

003

NAME: _____ PLACE OF EMPLOYMENT: _____

1. What is your occupation? Physiotherapist ☐ Occupational Therapist ☐
2. Are you covered by the present agreement between the Alberta Hospital Association and the ACPA and AAROT? YES ☐ NO ☐

THE FOLLOWING IS A LIST OF ISSUES THAT COULD BE DISCUSSED DURING THE UPCOMING NEGOTIATIONS WITH THE ALBERTA HOSPITAL ASSOCIATION. FOR EACH ISSUE, PLEASE INDICATE HOW IMPORTANT IT IS TO YOU.

	NOT IMPORTANT	FAIRLY IMPORTANT	VERY IMPORTANT
3. Sole charge therapists should be included on the Grade 11 Scale			
4. Pay for overtime should be increased			
5. Hours worked per week should be lowered			
6. Therapy Departments should be the sole determiners of what jobs are considered as part of the professional role of Therapists			
7. The employer should be required to provide written notice of any intention to lay off Therapists			
8. Pay for time ON CALL should be increased			
9. Vacation entitlement should be based on the number of years of continuous employment with any employer in Alberta			
10. Therapists' salaries should be protected from the effects of inflation by the inclusion of a cost of living adjustment (COLA) clause in the agreement with the employer			
11. Therapists should be paid full pay for each day of sick leave used regardless of number of illnesses suffered in a calendar year			
12. Therapists should receive an across the board salary increase			
13. A Therapist should be entitled to educational leave after three years of continuous employment with that employer			
14. No limit should be placed on the accumulation of sick leave credits			
15. The employer should fund a dental plan for Therapists			
16. Salary increments for each grade of Therapist should be extended to include pay levels for "AFTER FIVE YEARS" and "AFTER SIX YEARS".			
17. The starting salary for a Grade 11 Therapist should be equal to or greater than the "AFTER TWO YEARS" level for a Grade 1 Therapist			
18. Therapists receiving degrees should receive an automatic salary increase upon granting of degreed status			
19. All Therapists engaged on a part-time basis should be eligible for Grade 11 status and should be paid accordingly			

20. How satisfied with current working conditions are you? (circle a number)
VERY UNSATISFIED 1 2 3 4 5 6 7 8 9 10 VERY SATISFIED

21. How satisfied are you with the salaries presently paid to Therapists as an occupational group(circle a number)
VERY UNSATISFIED 1 2 3 4 5 6 7 8 9 10 VERY SATISFIED

ADDITIONAL COMMENTS:

APPPENDIX C

WEEKLY SALARIES - NURSES - ALL PROVINCES

YEAR	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA **	BC
1969	102	103	106	108	105	120	113	113	115 *	131
1970	110	117	115	111	126	130	125	123	125 *	142
1971	122	122	127	127	134	141	136	131	134	153
1972	123	132	134	138	142	151	144	137	141	165
1973	123	142	145	148	163	163	151	146	151	175
1974	158	NA	167	161	166	212	168	174	169	217
1975	172	NA	207	173	182	259	228	200	221	263
1976	220	NA	230	186	259	278	252	217	238	278
1977	222	NA	239	240	277	288	264	245	257	304
1978	235	NA	254	253	294	305	280	275	272	316
1979	244	NA	267	273	301	335	302	302	296	328
1980	292	NA	298	287	389	366	329	307	356	407
1981	297	NA	367	376	442	398	404	417	400	456
1982	424	NA	436	413	507	470	478	509	487	482
1983	465	NA	479	454	493	526	507	570	530	502
1984	466	NA	495	480	508	541	526	501	530	519
1985	468	NA	488	501	520	570	538	514	547	530

NOTE: 1. NA = DATA NOT AVAILABLE
2. SOURCES - QUESTIONNAIRES SENT TO VARIOUS ASSOCIATIONS ACROSS CANADA
- 'WAGE RATES, SALARIES AND HOURS OF LABOUR' , LABOUR CANADA
3. STARTING 1974 AVERAGE SALARIES ARE CALCULATED ON A CITY TO CITY BASIS
4. ** - DATA EXTRACTED FROM COLLECTIVE AGREEMENTS (FOR ALBERTA ONLY) EXCEPT WHERE DENOTED BY A
- SALARIES ARE ROUNDED TO THE NEAREST DOLLAR

WEEKLY SALARIES - LAB TECHNICIANS - ALL PROVINCES

YEAR	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA **	BC
1969	99	NA	104	100	100	113	106	105	106 *	127
1970	107	NA	107	110	119	122	116	118	125 *	150
1971	110	134	120	121	128	132	125	120	125 *	153
1972	112	NA	130	122	132	143	140	127	128 *	164
1973 ***	116	NA	135	127	137	149	146	132	133	171
1974 ***	121	NA	141	133	143	156	153	138	139	179
1975	142	NA	147	NA	140	196	204	222	204	192
1976	185	NA	157	NA	197	200	249	254	214	210
1977	188	NA	161	NA	238	231	196	249	226	219
1978	190	NA	171	NA	243	240	208	262	246	228
1979	193	NA	195	NA	250	252	240	280	267	247
1980	247	NA	211	NA	267	266	238	271	289	288
1981	259	NA	252	NA	303	288	275	366	312	310
1982	321	NA	297	NA	334	354	307	432	446	340
1983	374	NA	419	NA	357	371	318	478	470	369
1984	379	NA	419	NA	479	382	351	519	486	381
1985	398	NA	461	NA	473	395	367	519	504	387

NOTE: 1. NA = DATA NOT AVAILABLE
2. SOURCES - QUESTIONNAIRES SENT TO VARIOUS ASSOCIATIONS ACROSS CANADA
- 'WAGE RATES, SALARIES AND HOURS OF LABOUR' , LABOUR CANADA
3. STARTING 1974 AVERAGE SALARIES ARE CALCULATED ON A CITY TO CITY BASIS
4. ** - DATA EXTRACTED FROM COLLECTIVE AGREEMENTS (FOR ALBERTA ONLY) EXCEPT WHERE DENOTED BY A
- SALARIES ARE ROUNDED TO THE NEAREST DOLLAR
5. *** - DUE TO ERRORS IN DATA, A 4% CHANGE IN WAGES WAS USED FOR ALL PROVINCES IN 1973 AND 4.5%
(BASED ON THE ACTUAL EXPERIENCE I TA)

WEEKLY SALARIES - PHYSIOTHERAPISTS - ALL PROVINCES

YEAR	NFLD	PEI	NS	NB	QUE	ONT	MAN	SASK	ALTA **	BC
1969										
1970										
1971	NA	NA	NA	164	NA	NA	149	NA	135	NA
1972	NA	NA	NA	177	NA	NA	159	NA	140	NA
1973	NA	NA	164	189	179	182	168	156	153	191
1974	NA	NA	182	186	203	224	182	NA	167	224
1975	NA	NA	220	180	210	255	209	NA	227	284
1976	208	NA	244	201	281	290	236	NA	244	329
1977	250	NA	250	232	316	303	268	NA	258	321
1978	265	NA	258	265	350	321	284	NA	275	334
1979	276	NA	301	299	368	333	312	338	293	359
1980	332	NA	338	326	444	370	335	338	360	398
1981	352	NA	382	388	476	406	400	NA	398	447
1982	471	NA	456	383	541	493	461	NA	467	459
1983	509	NA	486	482	547	527	470	516	491	499
1984	543	NA	488	509	573	543	515	579	508	522
1985	522	NA	523	502	579	566	527	581	524	533

NOTE: 1. NA = DATA NOT AVAILABLE
2. SOURCES - QUESTIONNAIRES SENT TO VARIOUS ASSOCIATIONS ACROSS CANADA
- 'WAGE RATES, SALARIES AND HOURS OF LABOUR' , LABOUR CANADA
3. STARTING 1974 AVERAGE SALARIES ARE CALCULATED ON A CITY TO CITY BASIS
4. ** - DATA EXTRACTED FROM COLLECTIVE AGREEMENTS (FOR ALBERTA ONLY)
- SALARIES ARE ROUNDED TO THE NEAREST DOLLAR